

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13312

13338

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 114 Stevenson Lane				d. STREET ADDRESS 114 Stevenson Lane			
3. NAME OF DECEASED (Type or print) First MICHAEL Middle GRAHAM Last ANDREAE				4. DATE OF DEATH Month Dec. Day 12, Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 5, 1959		9. AGE (in years last birthday) - yrs.	IF UNDER 1 YEAR Months 8 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Norman Andreae				14. MOTHER'S MAIDEN NAME Jean Gowdy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Charles N. Andreae - 114 Stevenson Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 7240 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) from Came out of Night Town. I twisted Around Neck							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) and Strangled Baby					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Balto. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto 17				24a. REC'D BY REGISTRAR DEC 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Pinner	

2044-294XV3

Md

12/13/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Place of Death: _____

8. Cause of Death: _____

9. Manner of Death: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

13. Signature of Physician: _____

14. Signature of Nurse: _____

15. Signature of Undertaker: _____

16. Signature of Burial Society: _____

17. Signature of Cemetery: _____

18. Signature of Funeral Home: _____

19. Signature of Mortuary: _____

20. Signature of Embalmer: _____

21. Signature of Transporter: _____

22. Signature of Interment: _____

23. Signature of Burial: _____

24. Signature of Cremation: _____

25. Signature of Other: _____

13339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltes</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Baltes</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centersville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Randallstown, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Shady Grove Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i>		4. DATE OF DEATH <i>Dec 12 - 5 - 1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 26, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager, Dept Robinson Mills</i>		11. BIRTHPLACE (State or foreign country) <i>Baltes</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles Arnold</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Smith</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr Charles M Arnold 9216 Liberty Rd.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho - Pneumonia</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral accident</i> DUE TO <i>Generalized Arteriosclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 days</i> <i>year</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *Dec. 1*, 19*59* to *Dec. 5*, 19*59*, that I last saw the deceased alive on *Dec. 5*, 19*59*, and that death occurred at *7:30 PM*, from the causes and on the date stated above.

ACTUAL SIGNATURE <i>Wmmoner York</i>	DATE SIGNED <i>6 Sutton Ave, Centersville 28</i>
PHYSICIAN'S NAME (Type) <i>Wether Dee Fort</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Dec 8, 1959</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltes Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Young Byers - 8728 Liberty Rd.</i>		24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13314

13340

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson				c. LENGTH OF STAY IN 1b 6 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. STREET ADDRESS 2024 MOUNT ROYAL TERRACE			
3. NAME OF DECEASED (Type or print) First JAMES Middle CLAYTON Last ARTHUR				4. DATE OF DEATH Month DECEMBER Day 8 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/05	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY CITY WATER DEPT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES E. ARTHUR		14. MOTHER'S MAIDEN NAME CATHERINE JOHNSTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-03-0281		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) 10 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 10 YEARS						INTERVAL BETWEEN ONSET AND DEATH 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m. 59				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTO.				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 6/3/59 to 12/8/59 , that I last saw the deceased alive on 12/8/59 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED DEC 9 '59							
ACTUAL SIGNATURE William Newcomer, M.D.				PHYSICIAN'S NAME (Type) Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17th				24. REC'D BY REGISTRAR DATE DEC 9 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. King							

CERTIFICATE OF DEATH

WIFE WHITE

JAMES

CLAYTON

ARTHA

8

27

JAMES E. WHITE

1862-1901

1862-1901

2/2/02

2/2/02

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13341

CERTIFICATE OF DEATH

Reg. Dist. No.

13315

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gwynn Oak</u>		MARYLAND c. LENGTH OF STAY IN 1b <u>11 mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FUGSBURG Home</u>		e. STREET ADDRESS <u>9311 St. George Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mathilda Marie ASHAVER</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1879</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles Pleines</u>		14. MOTHER'S MAIDEN NAME <u>Rose Beck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Reedors Ave. Home Campidder</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Dec. 22nd</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 21 -</u> , 19 <u>59</u> , and that death occurred at <u>6:52 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts. Balto 7-12-23-57</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		M.D. <u>4108 Liberty Hts. Balto - 7-12-23-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO MD</u>	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>PA. Heemann</u>		ADDRESS <u>6067 Harf Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>					

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13342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7606 - 7 Mile Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence</u> <u>Bach</u>		4. DATE OF DEATH Month Day Year <u>12-13-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila - Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses Middleman</u>		14. MOTHER'S MAIDEN NAME <u>Blara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Regina Hyman - same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension C.V.D.</u> DUE TO <u>about 1 1/2 hr.</u> (c) <u>about 1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>about</u> 19 <u>58</u> , to <u>Dec 13, 1959</u> , that I last saw the deceased alive on <u>Dec. 12, 1959</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Highstein</u> M.D.		DATE SIGNED <u>12/14/59</u>	
PHYSICIAN'S NAME (Type) <u>G. HIGHSTEIN</u>		<u>Balto. 1, Md.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <u>12-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u> ADDRESS <u>2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13343

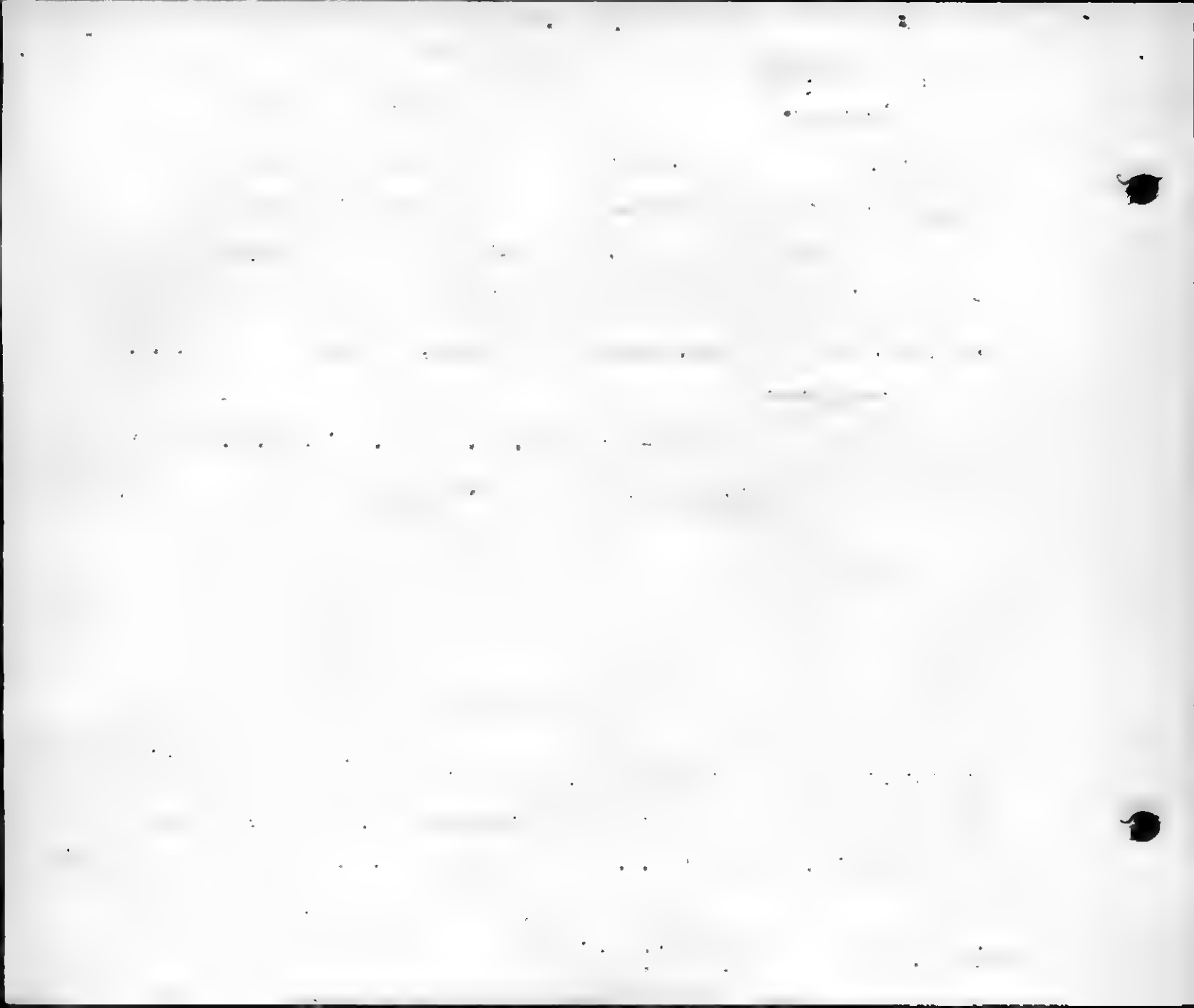
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 40 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVERETT Middle G. Last BAKER				4. DATE OF DEATH Month DECEMBER Day 25 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/90	
9. AGE (In years last birthday) yrs 69		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Detective				10b. KIND OF BUSINESS OR INDUSTRY Dept. Stores			
13. FATHER'S NAME George Baker				14. MOTHER'S MAIDEN NAME Anna UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 212-12-2714			
17. IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON TO LUNGS AND LIVER				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON TO LUNGS AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DOES LIVER DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/15/ 1959 to 12/25/ 1959 , and that death occurred at 4:10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter C. Goldstein, M.D. VAH, BALTO, MD. FORT HOWARD DIVISION							
ACTUAL SIGNATURE Walter C. Goldstein, M.D.				PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D. VAH, BALTO, MD. FT. HOWARD DIVISION 12/25/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRI SANDER & SONS North Ave. & Broadway Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Miller	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

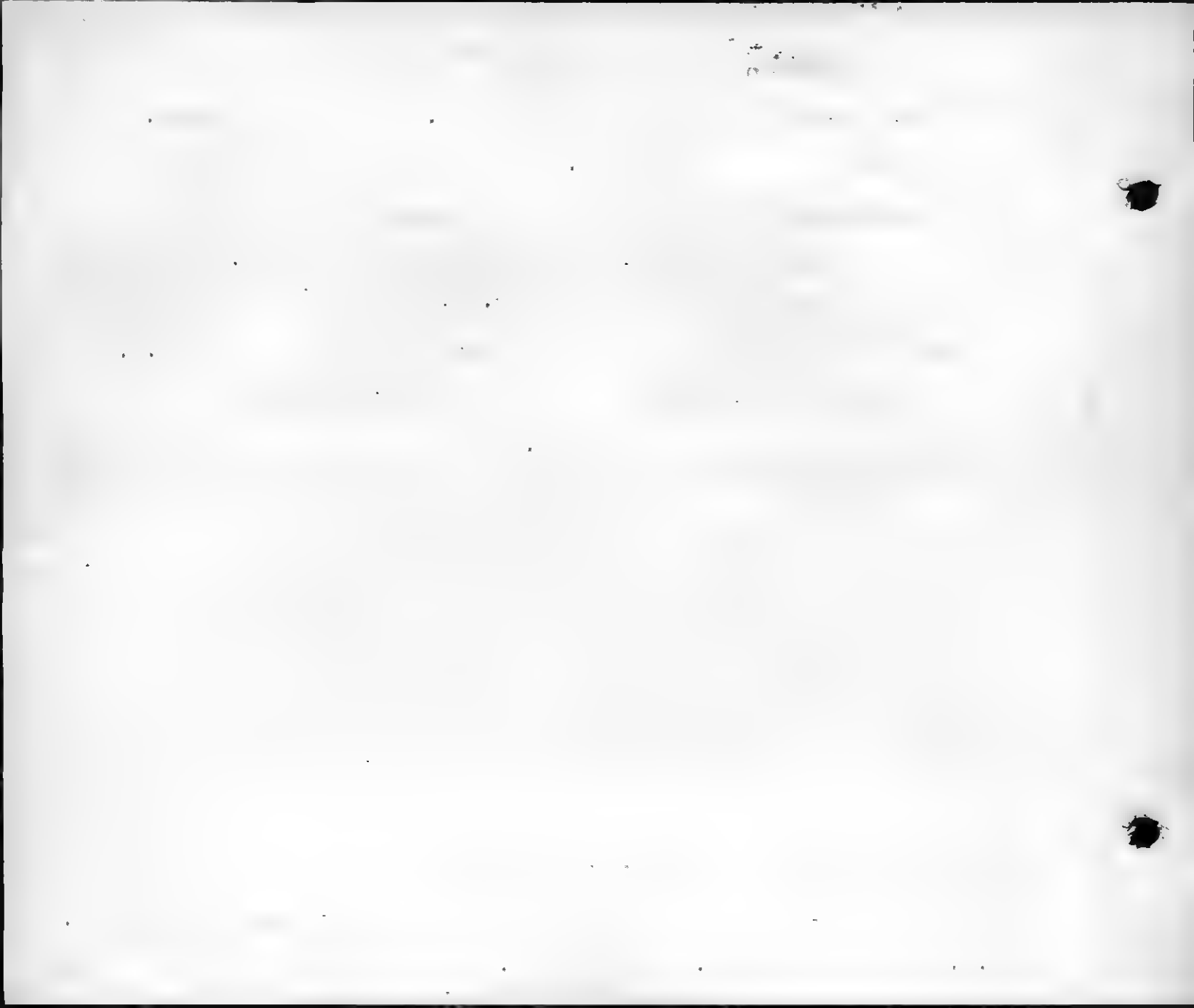
13318

13344

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton			
c. LENGTH OF STAY IN 1b 63 yrs.				d. STREET ADDRESS Woodbrook			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodbrook				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Hanson Baldwin				4. DATE OF DEATH Month Day Year Dec. 10 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1870		9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Aquilla Brown Hanson				14. MOTHER'S MAIDEN NAME Elizabeth Middleton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Summerfield Baldwin		INFORMANT Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO (b) Cerebral arteriosclerosis DUE TO (c) General arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 months 2 years Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 4 , 19 41 , to Dec 10 , 19 59 , that I last saw the deceased alive on Dec 10 , 19 59 , and that death occurred at 9:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Tilden Howard				ADDRESS (Street, city or town, state) 12 East Eager St, Balt, Md		DATE SIGNED Dec 11, 59	
PHYSICIAN'S NAME (Type) John Tilden Howard, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-59		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd.		24a. REC'D BY REGISTRAR DEC 14 59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanger	
Baltimore 12, Md.							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13345

CERTIFICATE OF DEATH

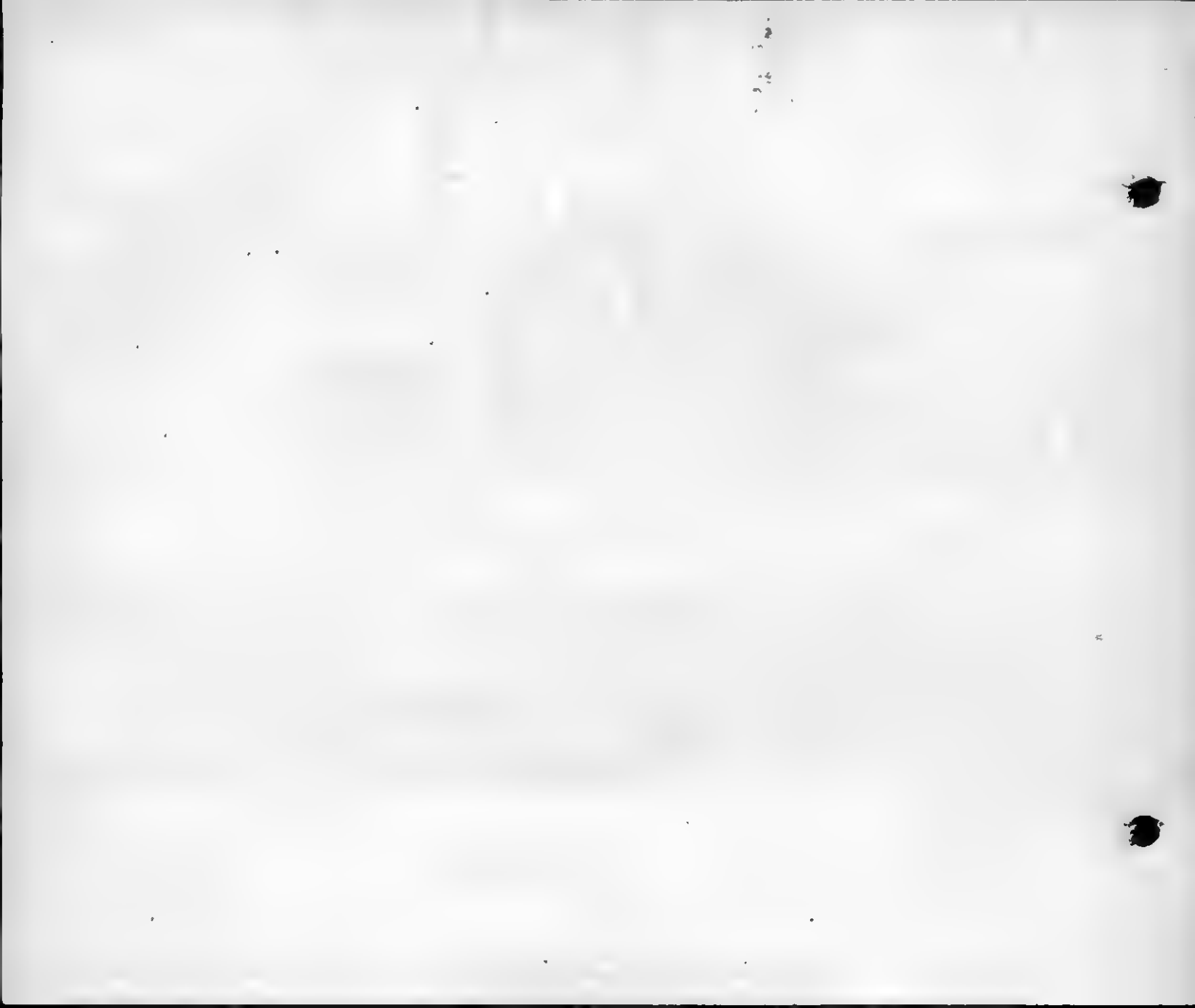
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4618 Old Court Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle Dean Last Bange		4. DATE OF DEATH Month Dec. Day 2 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1881
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George T. Bean	
14. MOTHER'S MAIDEN NAME Griselda Warfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT George Bange, Pikesville 8, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiac Disease 252.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Toxic goitre DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4/13 19 59 , to 12/2 19 59 , that I last saw the deceased alive on 12/2 19 59 , and that death occurred at 1:05 PM M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Grace G. Jones		ADDRESS (Street, city or town, state) 12 Walther Ave	
PHYSICIAN'S NAME (Type) Dr. Grace G. Jones Baltimore 8 - Md		DATE SIGNED 12/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Deer Park	22d. LOCATION (City, town, or county) (State) Reisterstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DEC 7 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hauer

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed **within 24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

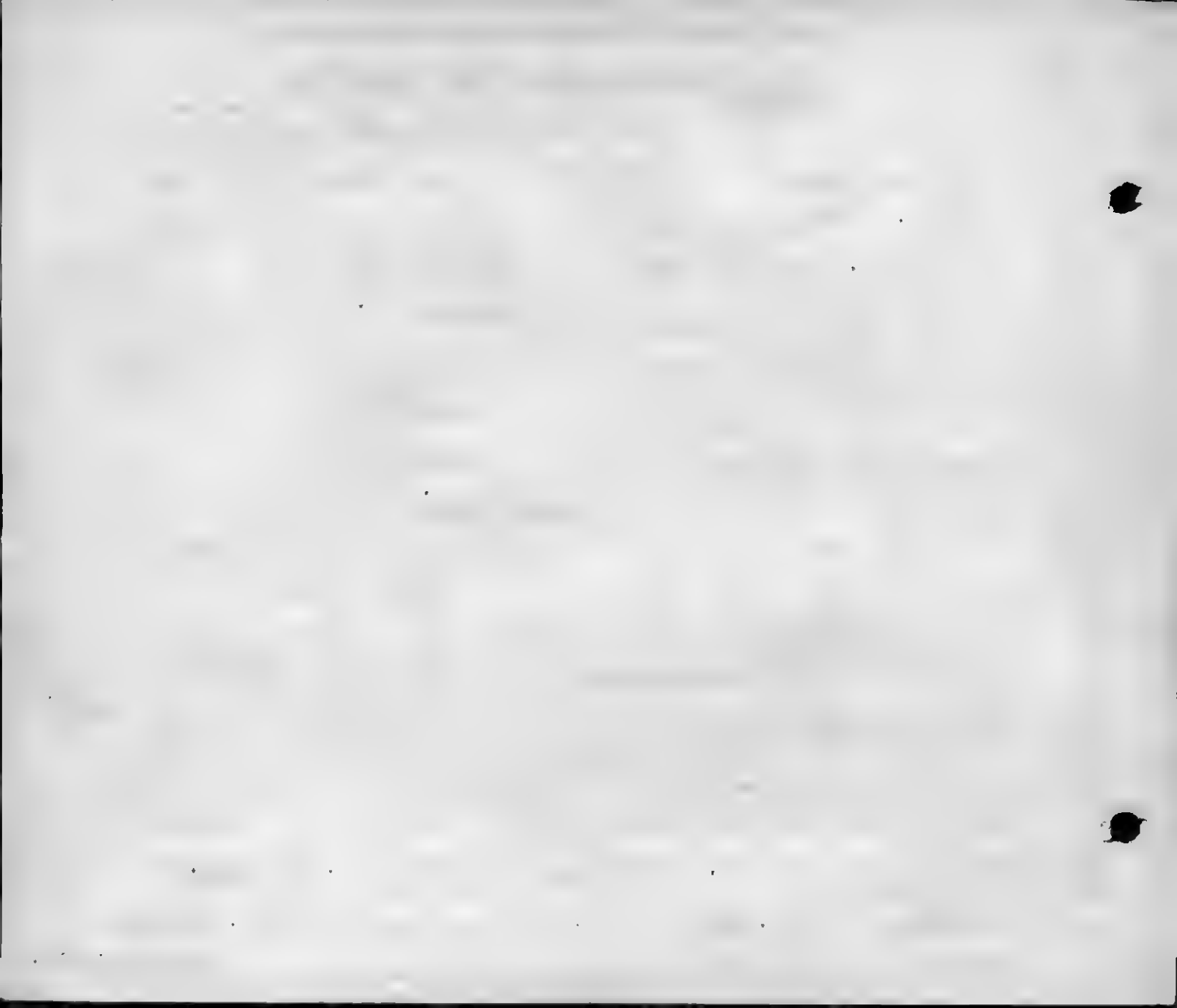
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13346

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto. City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson</u>		<u>68 mo.</u>		TOWN <u>Baltimore City 31</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Mt. Wilson State Hospital</u>				<u>1920 Bank St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
<u>Martin</u>				<u>Barrett Sr.</u>		<u>12 7 1959</u>	
6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	9. DATE OF BIRTH	10. AGE last birthday	11. IF UNDER 1 YEAR	12. IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>M</u>	<u>4/11/1887</u>	<u>72</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HUCKSTER</u>		<u>Grocery</u>		<u>Baltimore</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Bartley Barrett</u>				<u>Mary Flynn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>213-34-3544</u>		<u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 yrs.</u>	
IMMEDIATE CAUSE (A) <u>Far Advanced Pulmonary Tuberculosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/24</u> , 19 <u>54</u> , to <u>12/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/7</u> , 19 <u>59</u> , and that death occurred at <u>4:38 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 10, 1959</u>		<u>Mt. Carmel</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>DEC 10 '59</u>		<u>Arthur S. Kneib</u>		<u>Fuller-Zeller Inc.</u>		<u>1901 Eastern Ave.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13321

13347

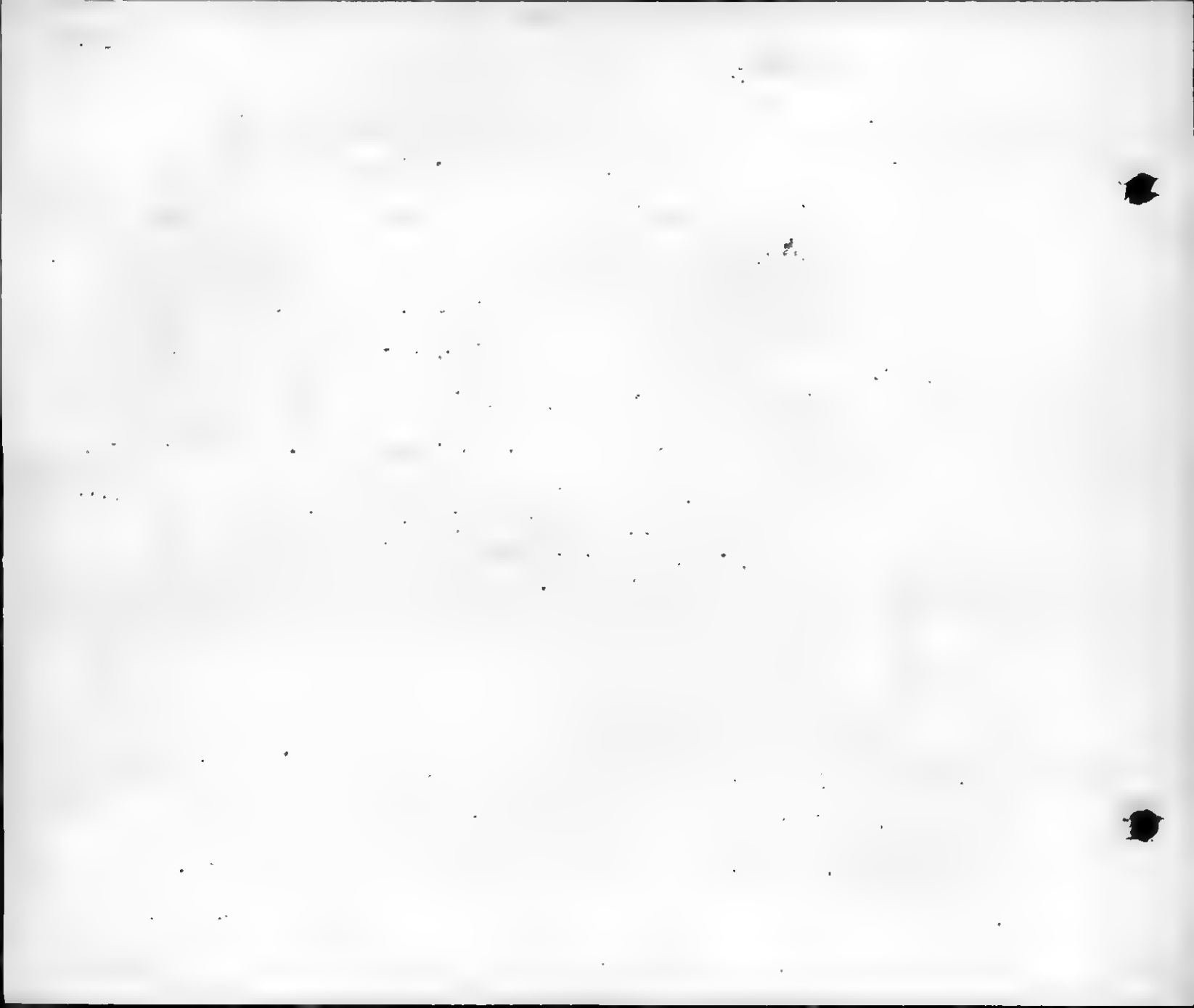
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F Last BAUGHER				4. DATE OF DEATH Month December Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1895	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.		11. IF UNDER 24 HRS. Months 64 Days 64 Hours 64 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Balto. Maryland	
13. FATHER'S NAME William Rebocker Baugher				14. MOTHER'S MARDEN NAME Ida Rose Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 705-05-7489			
17. INFORMANT Clin. Rec. VA Hosp Balto Md Ft Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ADRENAL GLAND RIGHT DUE TO METASTATIC CARCINOMA TO LIVER, LUNGS AND PERIAORTIC AND TRACHEOBRONCHIAL LYMPH NODES (b) BRONCHOPNEUMONIA (c) EDEMA OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17.17							
INTERVAL BETWEEN ONSET AND DEATH Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 22, 1959 to December 28, 1959 and that death occurred at 12:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH BALTO MD FT HOWARD DIVISION DATE SIGNED 12/28/59							
ACTUAL SIGNATURE Clovis M Snyder M.D. VAH BALTO MD FT HOWARD DIVISION							
PHYSICIAN'S NAME (Type) CLOVIS M SNYDER VAH BALTO MD FT HOWARD DIVISION 12/28/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF December 31, 1959			
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Frank H Newell Inc. Reisterstown Rd & Waldron Ave				24a. REC'D BY REGISTRAR DEC 30 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				Pikesville, Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G235 12/9/59 iwk

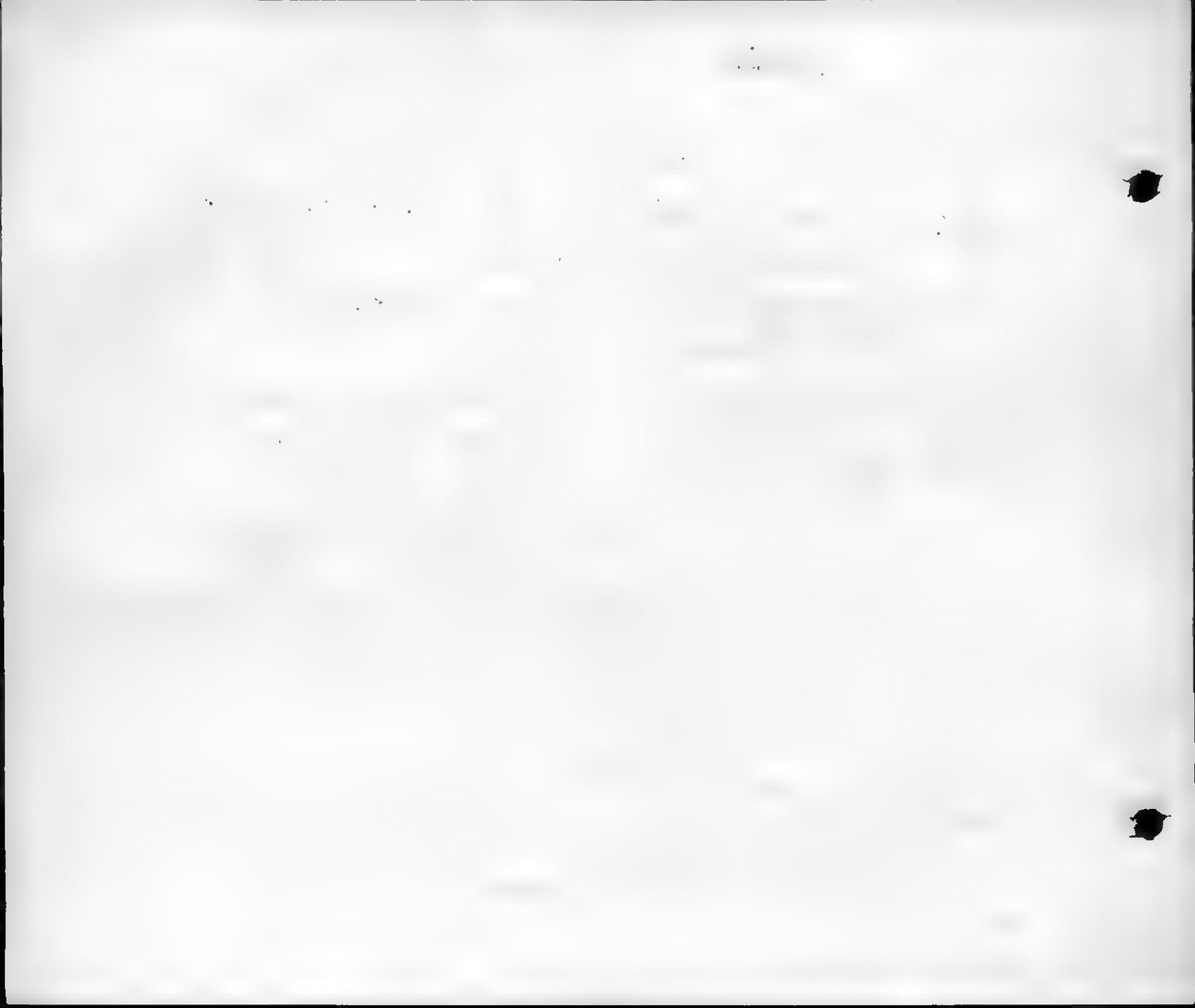
13348

CERTIFICATE OF DEATH

Reg. Dist. No.

13322

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.			
c. LENGTH OF STAY IN 1b 8 wks. (Private Home)				d. STREET ADDRESS 263 S. CONKLING ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 STUART ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THERESA First Middle Last BERLETT				4. DATE OF DEATH DEC. Month 4 Day 1959 Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 24, 1884	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS RAW				14. MOTHER'S MAIDEN NAME THERESA KURTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach metastases DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH				18. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from SEPT. 15 , 19 59 , to DEC. 7 , 19 59 , that I last saw the deceased alive on Dec. 7 , 19 59 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Orth				ADDRESS (Street, city or town, state) 8019 PHILA. RD.			
PHYSICIAN'S NAME (Type) JOHN G. ORTH				DATE SIGNED BALTO. 6, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DEC. 8, 1959				22b. DATE THEREOF			
22c. NAME OF CEMETERY ZION LUTH. CHURCH				22d. LOCATION (City, town, or county) (State) BALTO. CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann				ADDRESS 3218 HUDSON ST			
24a. REC'D BY REGISTRAR DEC 7 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4 Film G253 12-14-59 et
13349
CERTIFICATE OF DEATH

13323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS c. LENGTH OF STAY IN 1b 2yrs 8mo.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 135 N. Chapel Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARCELLO ANGELO BLACK First Middle Last		4. DATE OF DEATH Month December Day 5 Year 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 3 yrs. IF UNDER 1 YEAR: Months — Days — Hours — Min — IF UNDER 24 HRS: Months — Days — Hours — Min —
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JAMES C BLACK		14. MOTHER'S MAIDEN NAME ESTELLE L. WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) rapid decompression of hydrocephalus DUE TO — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital internal hydrocephalus severe mental deficiency DUE TO — (c) —		INTERVAL BETWEEN ONSET AND DEATH 2da Since birth 3yr. 9mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic quadriplegia Generalized convulsions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 12 , 19 57 to Dec 5 , 19 59 , that I last saw the deceased alive on Dec 5 , 19 59 , and that death occurred at 3:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Maryland DATE SIGNED Dec 5, 1959 ACTUAL SIGNATURE Olive Reid Harris, M.D. PHYSICIAN'S NAME (Type) Olive Reid Harris, M.D. maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Gary Cem.		22d. LOCATION (City, town, or county) (State) Cedar Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E.O. Walz		24a. TESTED BY REGISTRAR DEC 8 59 24b. REGISTRAR'S SIGNATURE Arthur B. Harris	



CERTIFICATE OF DEATH

Reg. Dist. No.

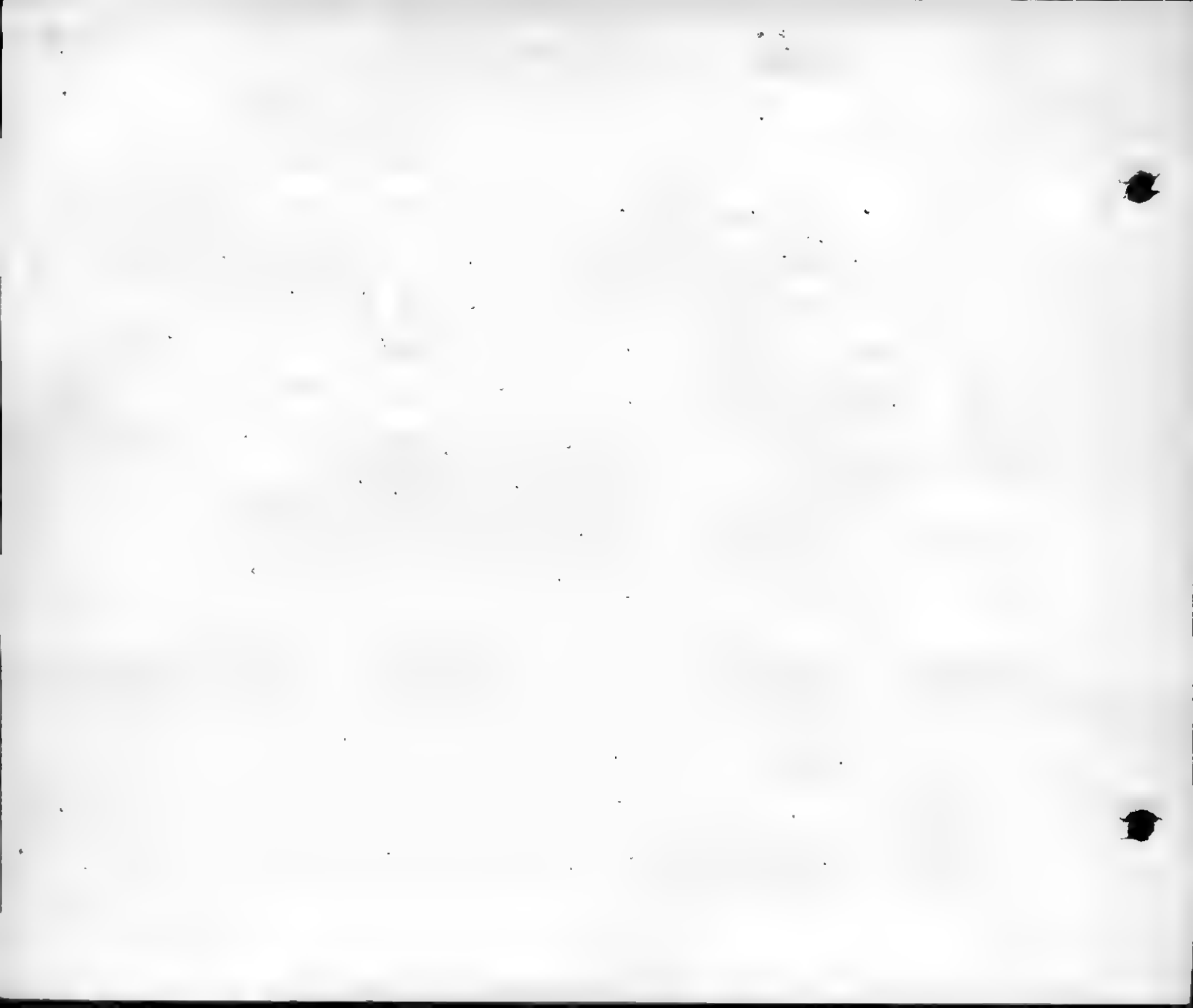
13324

13350

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto. City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>3:14</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paradise Conv. Home</i>		d. STREET ADDRESS <i>821 Stricker St.</i>	
3. NAME OF DECEASED (Type or print) <i>Walter</i> First <i>Bloom</i> Middle Last		4. DATE OF DEATH <i>Dec. 20</i> 19 <i>59</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12/30/1879</i> 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Granville Bloom</i>		14. MOTHER'S MAIDEN NAME <i>Hester Webster</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT Evelyn Carr-Catonsville Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemiplegia left</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cerebral Vascular Accident</i> DUE TO (c) <i>Degenerative Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1958</i> to <i>12/20/59</i> , that I last saw the deceased alive on <i>12/20/59</i> , 19 <i>59</i> , and that death occurred at <i>8:05 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. F. McGroth</i> M.D.		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 28 Md.</i> DATE SIGNED <i>12/21/59</i>	
PHYSICIAN'S NAME (Type) <i>W. F. McGroth</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/24/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Salem Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Winfield-Carroll Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nutter & Son</i> ADDRESS <i>Catonsville - 28</i>		24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13351

CERTIFICATE OF DEATH

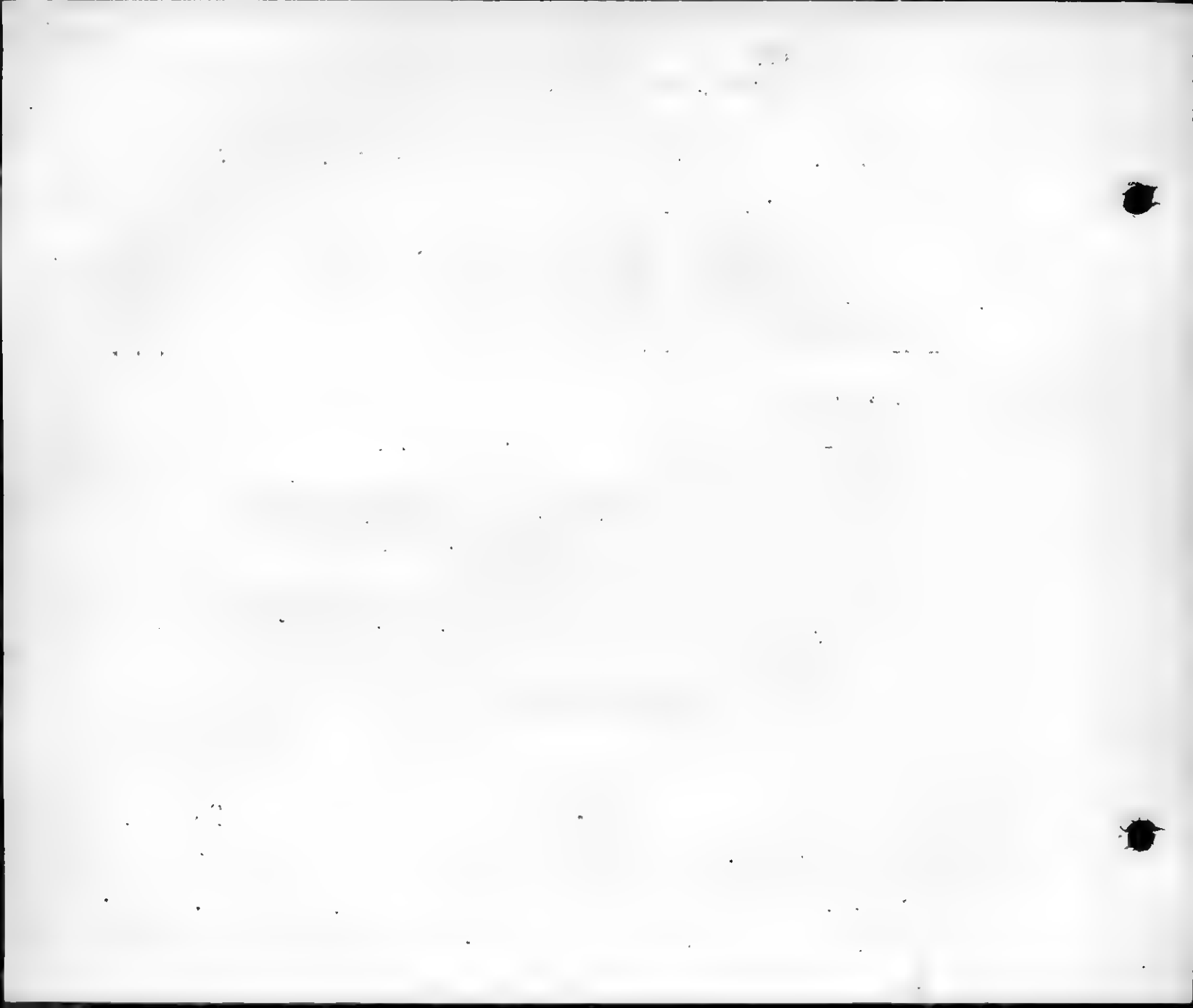
Reg. Dist. No.

13325

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)			
a. COUNTY <u>Baltimore</u>		MARYLAND		a. STATE <u>Maryland</u>		b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>West Hyattsville, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>5714 16th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Keith</u> Middle <u>Ian</u> Last <u>Bond</u>		4. DATE OF DEATH		Month <u>12</u> Day <u>14</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/52</u>		9. AGE (In years last birthday) yrs <u>7</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Normond E. Bond</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Sybilia Cavellier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bronchopneumonia and pulmonary abscesses, left complicated by laryngeal edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO <u>---</u> (c) DUE TO <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism with intermenstrual septal defect</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:50p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Pet W. Rieckert Pathologist 4307 Mainfield Ave 12/15/59</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert Baltimore 14, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer, Sons, Rustertown Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13352

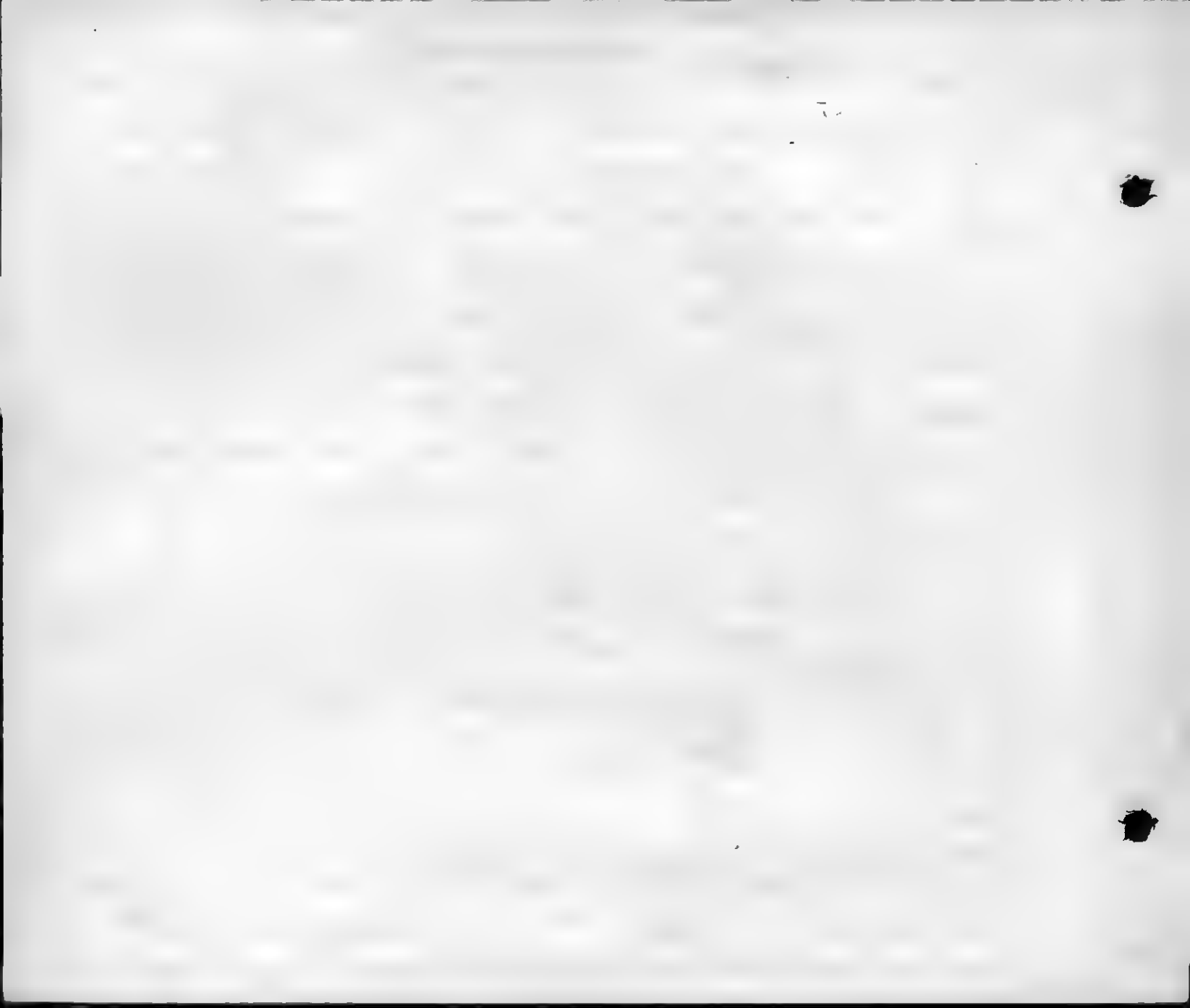
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME				e. STREET ADDRESS 3042 EDGEWOOD AVE			
3. NAME OF DECEASED First HENRY Middle BOWERS Last BOWERS				4. DATE OF DEATH Month 12 Day 20 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 16, 1884	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months 2 Days 4	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME George Bowers				14. MOTHER'S MAIDEN NAME Theresa ROMOSER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-09-5512			
				17. INFORMANT Miss Janetta Bowers Address 3042 Edgewood Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4 a d. i DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 24, 1959 to Dec 20, 1959 , that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry C. Knipp M.D.				ADDRESS (Street, city or town, state) 4116 Edgewood Ave, Baltimore, Md.			
PHYSICIAN'S NAME (Type) HARRY C. KNIPP M.D.				DATE SIGNED 12/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-23-59		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or county) (State) Baltimore MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin ADDRESS 1902 Gutter Place				24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13353

CERTIFICATE OF DEATH

13327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALL TOWN RURAL</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				d. STREET ADDRESS <u>UNION BRIDGE ROAD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓ private residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANN BOWMAN</u>				4. DATE OF DEATH Month Day Year <u>DEC 20 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 4 - 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CUN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STEINER WACHTER</u>				14. MOTHER'S MAIDEN NAME <u>PATSY STOFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>226-18-3315</u>		17. INFORMANT <u>CLETUS BOWMAN NEW WINDSOR MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA CERVIX</u> DUE TO Conditions, if any, which gave rise to immediate causa (a), stating the underlying cause last. (b) _____ (c) <u>GENERALIZED CARCINOMATOSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5-6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EDEMA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>12/11/59</u> , 19 <u>59</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Webster</u> M.D.				ADDRESS (Street, city or town, state) <u>111 W. MINORUM ST</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS C. WEBSTER</u>				DATE SIGNED <u>12/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. HARTLEY & Sons New Windsor Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



CERTIFICATE OF DEATH

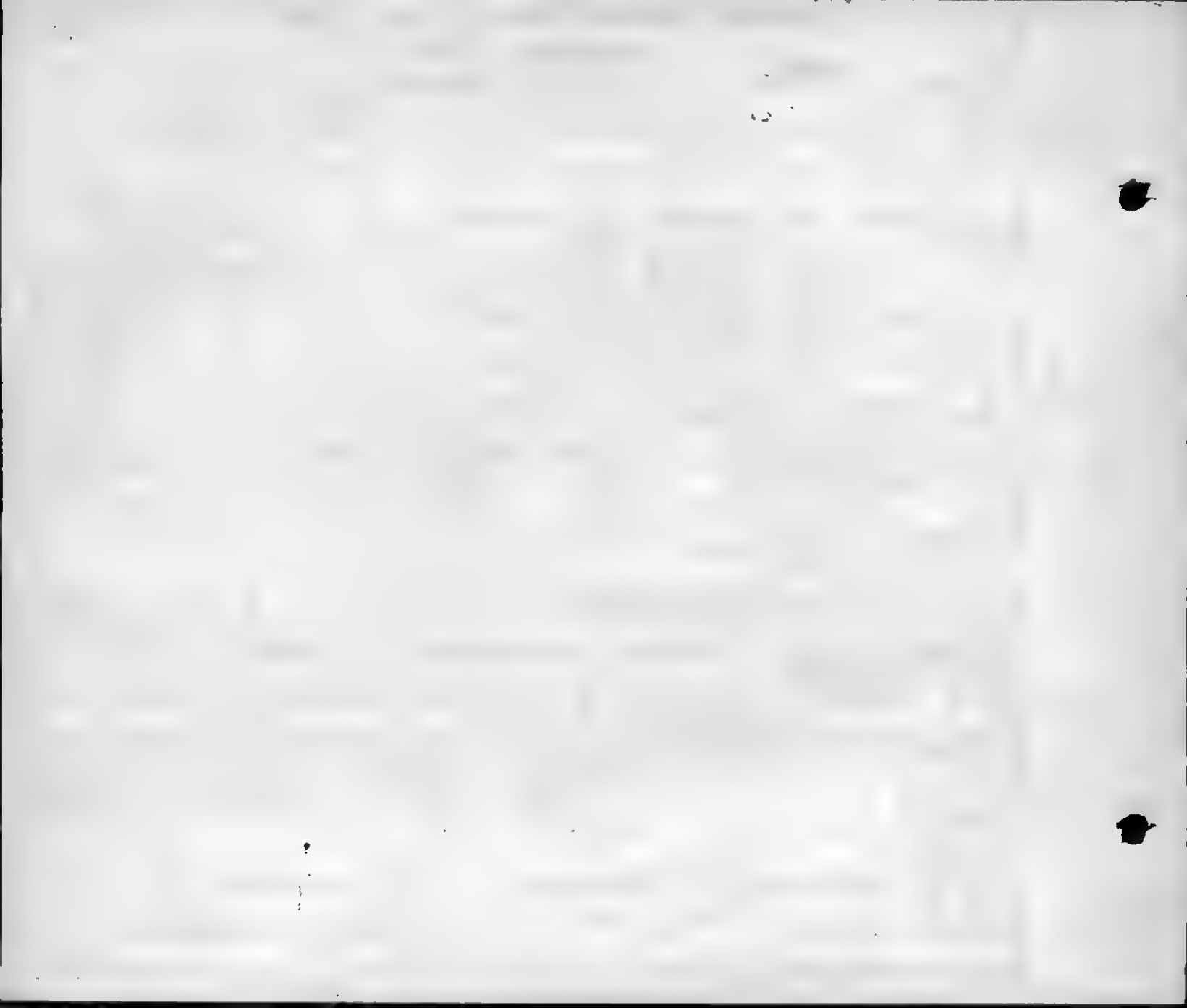
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>8 1/2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifton Clark Brown</u>		4. DATE OF DEATH Month Day Year <u>Dec. 16 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 1-1959</u>
9. AGE (In years last birthday) <u>8 1/2 mo</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>University Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilson Clark Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Wender</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Nelson Brown</u>		Address <u>Fallston Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Fulminating Broncho-</u> DUE TO <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>59</u> , to <u>12/16</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12/15</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>FORK MD</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 19 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Falbertack Ave</u>	22d. LOCATION (City, town, or county) (State) <u>Benson Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Archer</u>		ADDRESS <u>Benson Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 21 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [illegible]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13355

CERTIFICATE OF DEATH

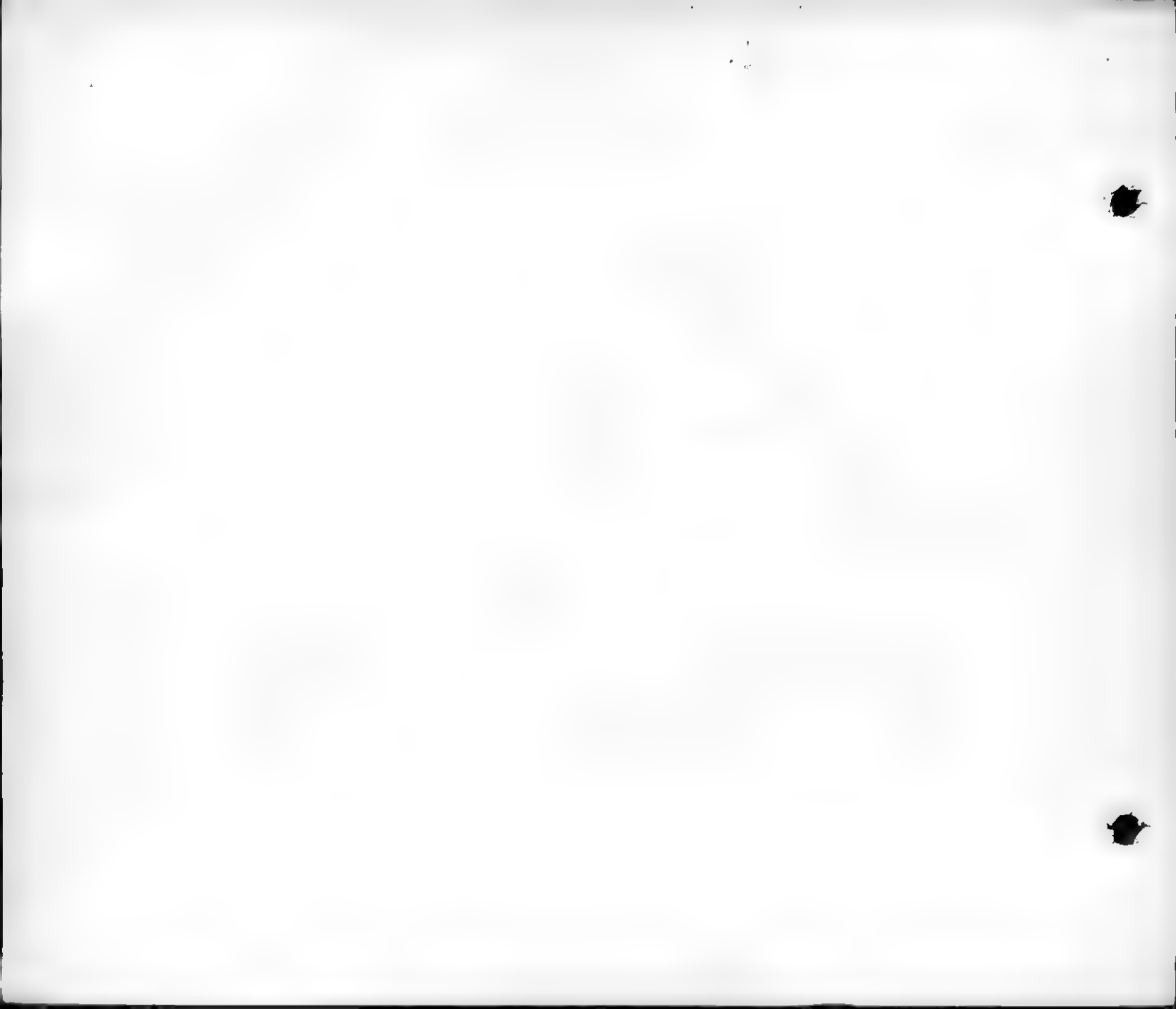
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville, Md.</u>	LENGTH OF STAY OR (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville, Md.</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 273 Falls Rd.</u>		STREET ADDRESS (If rural give location) <u>Box 273 Falls Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Elias</u> (Middle) <u>Herman</u> (Last) <u>Brown</u>		(Month) <u>Dec</u> (Day) <u>5</u> (Year) <u>1959</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Aug 12 1888</u>
9. AGE last birthday: <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Dry Goods</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Elias Herman Brown</u>		14. MOTHER'S MAIDEN NAME: <u>Florence Hardcastle</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>215-05-5755</u>	
(If Yes, give war or dates of service) <u>World War I</u>		17. INFORMANT & ADDRESS: <u>Son, Elias Herman Brown</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>Myocardial Infarction</u>		<u>1951 + 36 mos.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Nephrosclerosis due to</u>		<u>2 years</u>	
(c) <u>Arteriosclerotic CV Dis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>59</u> , to <u>Dec 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>59</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Lester G. Hall Jr. M.D.</u>		DATE SIGNED <u>Dec 5 1959</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/8/1959</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>DEC 8 '59</u>		REGISTRAR'S SIGNATURE <u>Charles E. House</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Hgts. Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

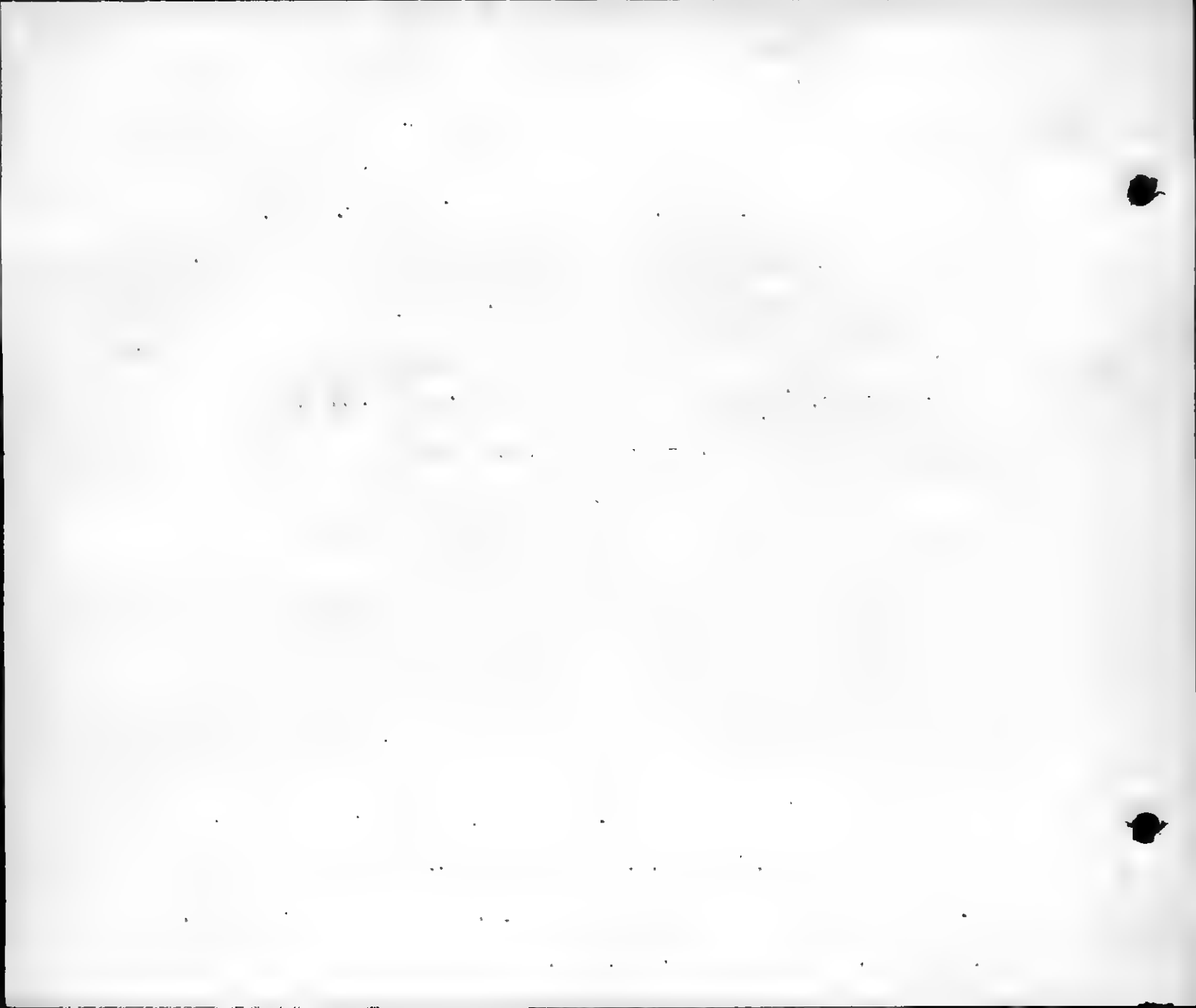
13356 CERTIFICATE OF DEATH

13330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8208 Harford Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>8208 Harford Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>Bucher</u> Last <u>Bucher</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1959</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 6, 1893</u> 9. AGE (In years last birthday) yrs. <u>66</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Benjamin B. Bucher</u>			14. MOTHER'S MARRIED NAME <u>Laura V. Marple</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO <u>217-01-6864</u>		INFORMANT <u>Laura Bucher</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Cirrhosis of Liver</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 17, 1959</u> to <u>Dec. 17, 1959</u> , that I last saw the deceased alive on <u>Dec. 17, 1959</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold H. Burns</u> M.D.		ADDRESS (Street, city or town, state) <u>8106 Harford Rd. #4</u> DATE SIGNED <u>12-21-59</u>					
PHYSICIAN'S NAME (Type) <u>Harold H. Burns M.D.</u>		<u>Balto. # 2 Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>					
24a. REC'D BY REGISTRAR <u>DEC 23 59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hays</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13331

13328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Residence, 7638 Old Battle Grove Rd.</u>		d. STREET ADDRESS <u>7638 Old Battle Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>19 9</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1894</u>
9. AGE (in years) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>169-03-5710</u>	
17. INFORMANT <u>Mrs. Cecilia Budny</u>		Address <u>7638 Old Battle G.r.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Chronic Cerebral</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. W. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-9-57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. 22, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13352

13357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> c. LENGTH OF STAY IN TB <u>5 min.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hampstead</u> d. STREET ADDRESS <u>Beckleysville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Raymond Bull</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u>		5. SEX <u>M</u>							
6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1914</u>							
9. AGE (In years last birthday) <u>45</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit Co.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
11. BIRTHPLACE (State or foreign country) <u>Farkton Md. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Samuel Jacob Bull</u>							
14. MOTHER'S MAIDEN NAME <u>Beulah Shaffer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>M. Adeline Bull</u>							
17. INFORMANT <u>M. Adeline Bull</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest, compound fracture</u> DUE TO <u>lower right leg, numerous lacerations</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck a bridge abutment.</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>10.30 12/7/59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> or at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>							
20f. (City or town) <u>Beckleysville, Balto.</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>R. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/8/59</u>							
EXAMINER'S NAME (Type) <u>A. M. France</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>							
22d. LOCATION (City, town, or county) <u>Farkton Md. D.C.</u>		22e. (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Local Funeral Home - Freedom Pa.</u>							
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE <u>DEC 14 '59</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

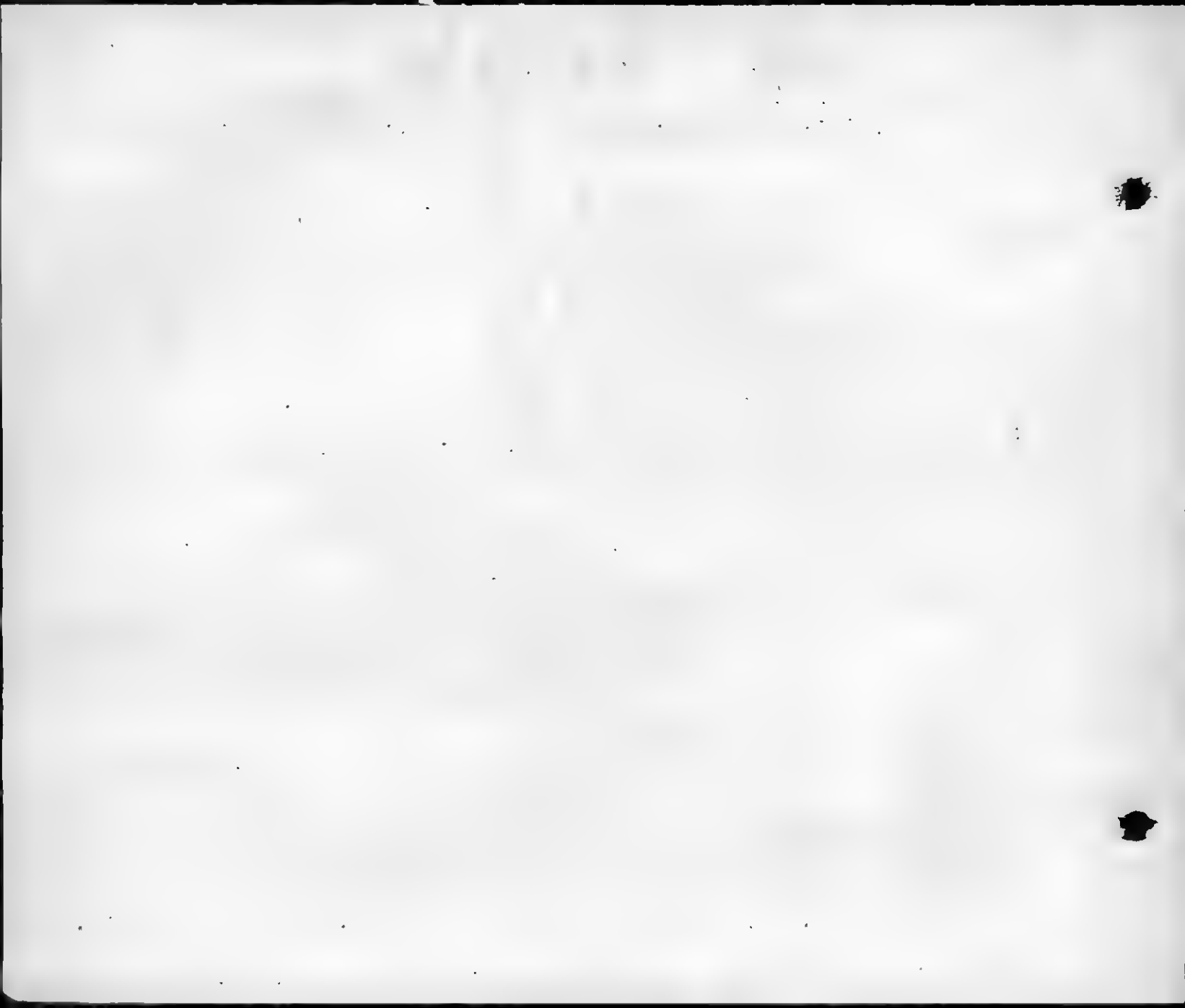
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13358 CERTIFICATE OF DEATH

13333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5534 Clifton Ave. #7.</u>		d. STREET ADDRESS <u>5534 Clifton Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>LEROY M. Burch JR</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-18</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Leroy M. Burch, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walker.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>(Yes)</u>		16. SOCIAL SECURITY NO. <u>215-05-1720</u>	
17. INFORMANT <u>Mrs. Mildred Burch</u>		Address <u>5534 Clifton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Tracheal obstruction</u> DUE TO (b) <u>Post-operative edema of the neck.</u> DUE TO (c) <u>Epileptic convulsions</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Narcolepsy</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-6-</u> , 19 <u>59</u> , to <u>12-19-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-21-</u> , 19 <u>59</u> , and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Vela</u>		DATE SIGNED <u>12-22-59</u>	
PHYSICIAN'S NAME (Type) <u>G. Vela</u>		M.D. <u>G. Vela</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 26, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill RD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

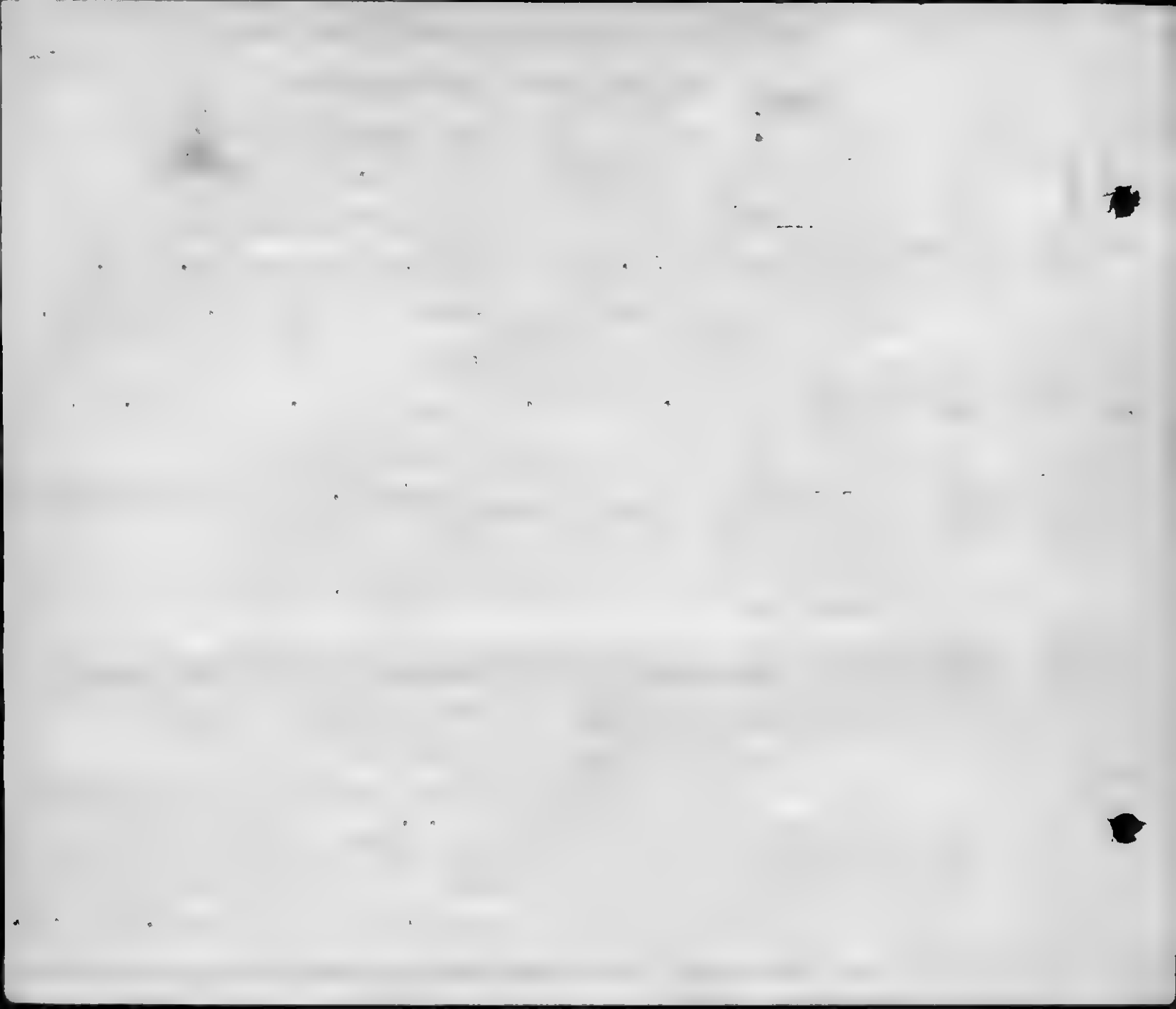
13329

CERTIFICATE OF DEATH

13334

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>	
TOWN <u>Turners Station</u>		LENGTH OF STAY (In this place)		STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 6 Maryland Ave. # 22</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 6 Maryland Ave. # 22</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>FREDERICK</u>		(Last) <u>BURKHARDT</u>		(Date) <u>Dec. 28, 1959</u>	
(Type or Print)		(Type or Print)		(Type or Print)		(Type or Print)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 18, 1892</u>	
9. AGE last birthday <u>67</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. IF UNDER 24 HRS.	
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Smelt & Ref.</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Burkhardt</u>				14. MOTHER'S MAIDEN NAME <u>Florence Schneider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
<u>Louise U. Burkhardt</u>				<u>Same.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>				<u>24 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C-V disease</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. Emphysema with Asthma</u>				<u>20 years</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)				21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 23, 1959</u> to <u>Dec 28, 1959</u> that I last saw the deceased alive on <u>Dec 28, 1959</u> and that death occurred at <u>8:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>30 Dec '59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>12-31-59</u>				NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>			
LOCATION (City, town, or county) (State) <u>4430 Belair Rd. Balto. Md.</u>							
25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>401 S. CONKLING ST. BALTO, MD.</u>			
DATE <u>DEC 31 '59</u>							



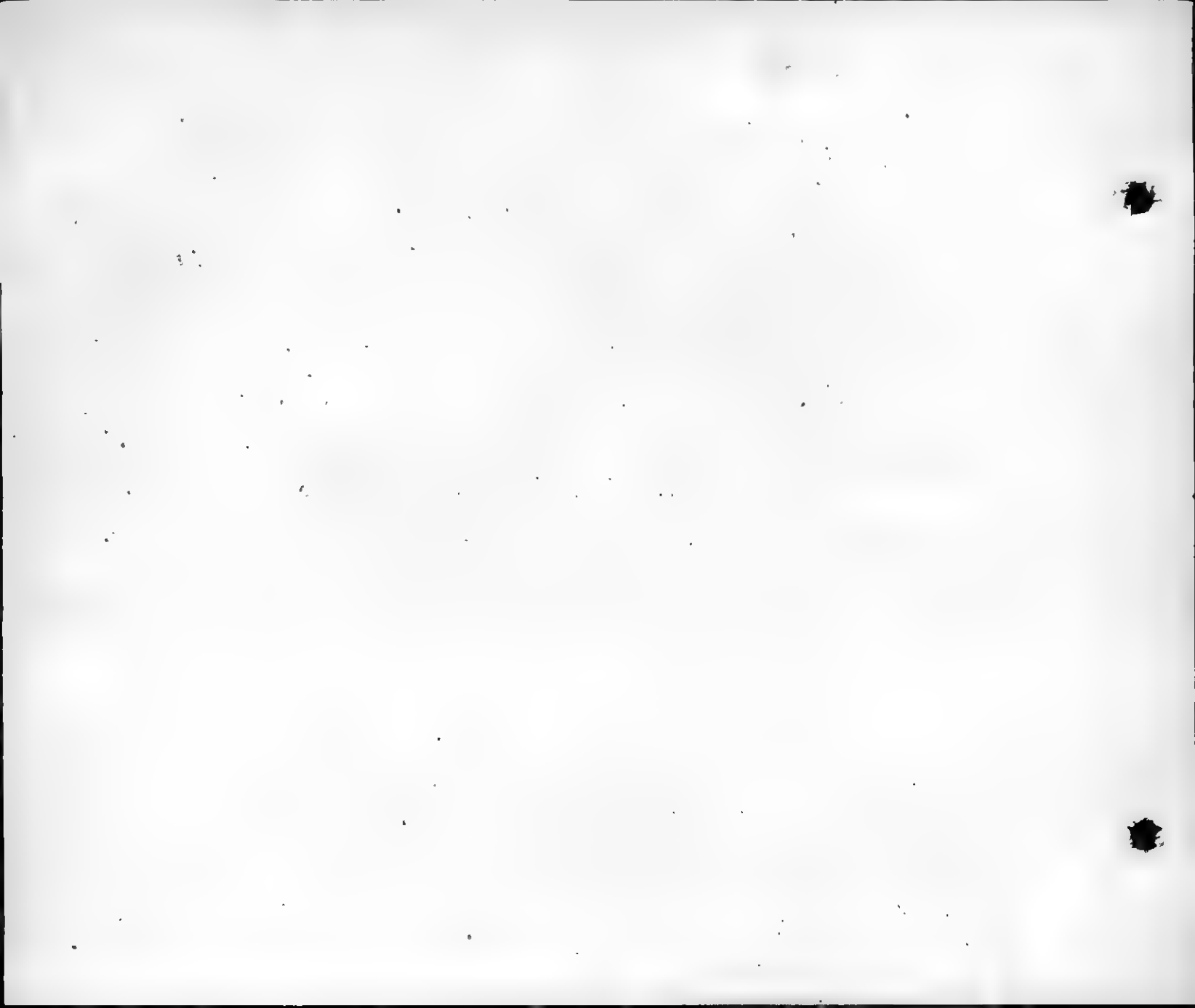
13359

CERTIFICATE OF DEATH

Reg. Dist. No.

13335

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graystone Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William J. Burns</u>		4. DATE OF DEATH Month Day Year <u>December 28, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wesley Burns</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Cardiac Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 19, 49</u> to <u>Dec 28, 1959</u> that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer Bothe</u> M.D.		ADDRESS (Street, city or town, state) <u>Dec 28, 59</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Md. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Venturini</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on in any event within 72 hours after death.

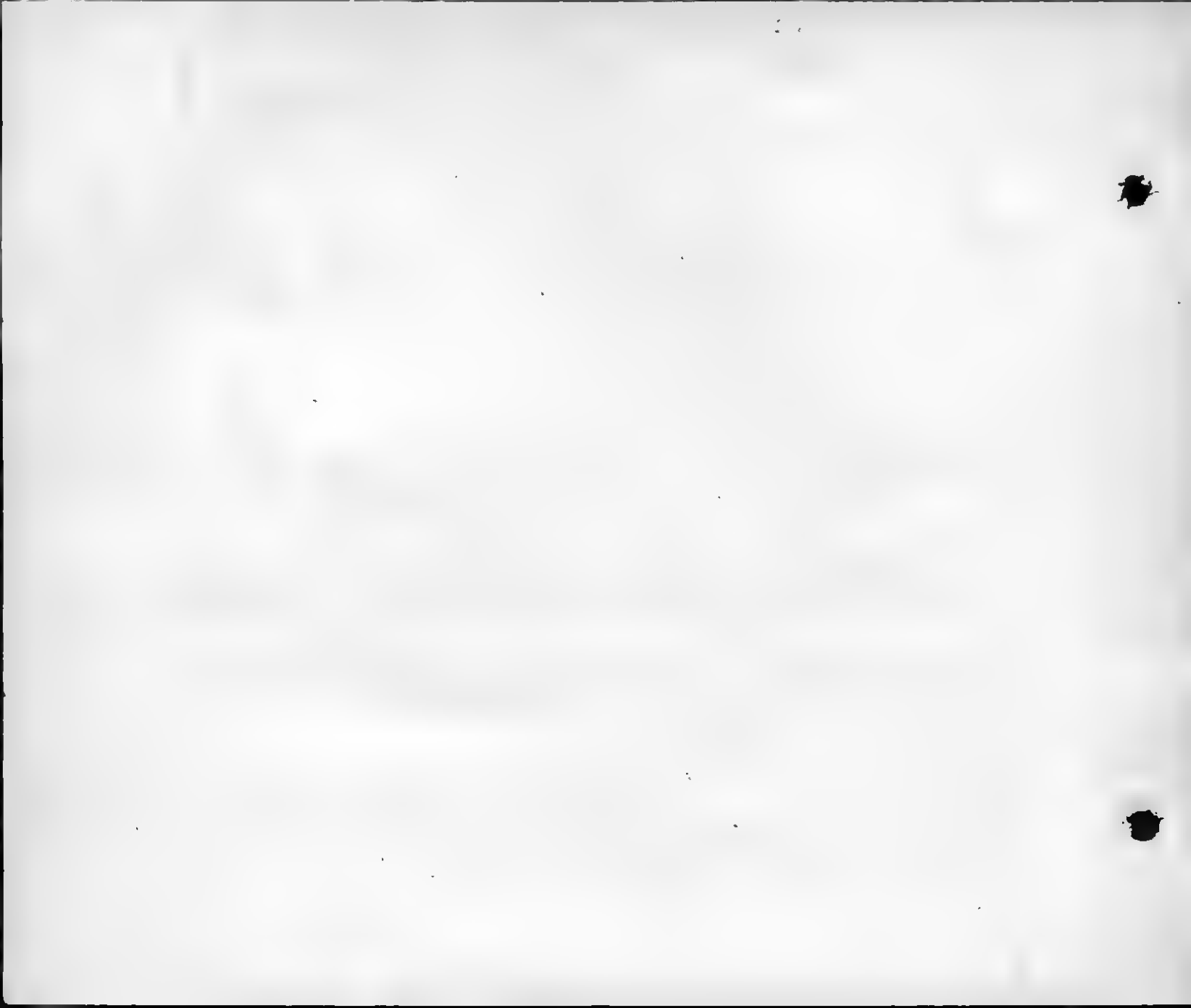
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Erie</u> 75 x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3306 Gwynndale Ave.</u>		d. STREET ADDRESS <u>956 Brown's Ave</u>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Ebba C. Carlson</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min <u>59</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>August Hanson</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Matilda Hanson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Louise Carlson - 5306 Gwynndale Ave</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid</u> <u>1583</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> 19 to <u>1959</u> , that I last saw the deceased alive on <u>Sept</u> , 1959, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.V. Harper</u> M.D.		ADDRESS (Street, city or town, State) <u>5201 Leverage Oak Ave</u> DATE SIGNED <u>Dec 7 1959</u>	
PHYSICIAN'S NAME (Type) <u>H.V. HARPER</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/17/59</u>	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>ERIE CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>ERIE PENNSYLVANIA</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13361

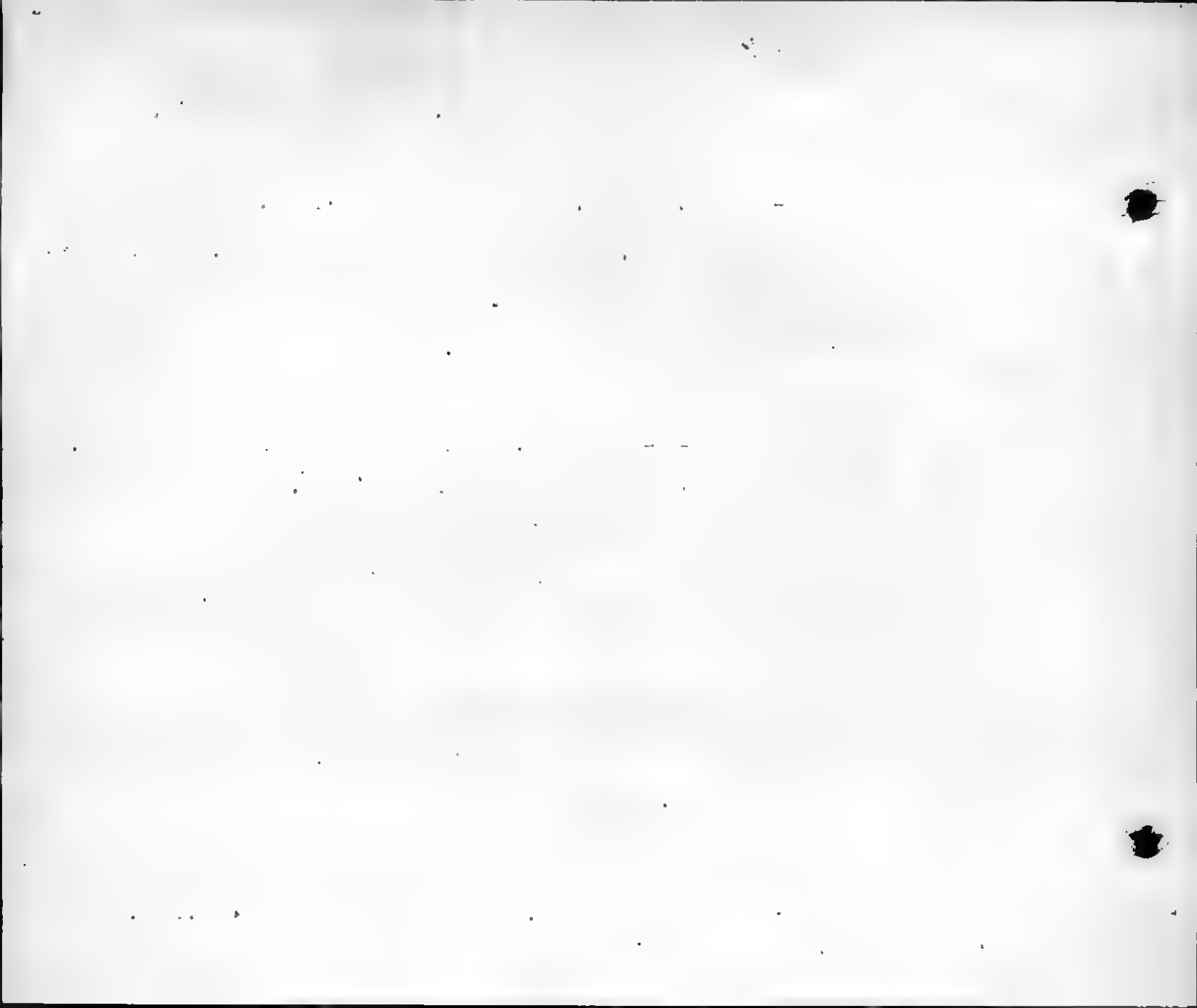
CERTIFICATE OF DEATH

13337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home-98 Smithwood Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 5604 Gwynn Oak Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle J. Last CARRICK		4. DATE OF DEATH Month Dec. Day 15, Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-12-4630	
17. INFORMANT Mrs. Pauline Collins		Address - 5604 Gwynn Oak Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 Congestive Heart Failure DUE TO Acute & chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Disease Degenerative Type DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 59 to 12/15/59 , that I last saw the deceased alive on 12/14/59 and that death occurred at 12:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. McGrath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 Md	
PHYSICIAN'S NAME (Type) W. E. McGrath		DATE SIGNED 12/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/18/59	22c. NAME OF CEMETERY OR CREMATORY Western Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Balto, Md		24a. REC'D BY REGISTRAR DEC 16 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13362

CERTIFICATE OF DEATH

Reg. Dist. No.

32

13358

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> <u>2040</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>117 THOROGOOD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL</u> <u>LEE</u> <u>CARTER</u>		4. DATE OF DEATH Month Day Year <u>12</u> - <u>11</u> - <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-29</u>
9. AGE (In years last birthday) <u>30</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UPHOLSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UPHOLSTERING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES CARTER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE SIFT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-20-8492</u>	
17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ABSCESS OF LUNG</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningitis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4-1959</u> to <u>12-11-1959</u> , that I last saw the deceased alive on <u>12-10-1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Mt. Wilson, Maryland</u> <u>12-11-59</u>			
ACTUAL SIGNATURE <u>William Newcomer, M.D.</u>		M.D. <u>Superintendent</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec. 16 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Grave</u>		22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u>		ADDRESS <u>Annapolis Ind</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



13363

CERTIFICATE OF DEATH

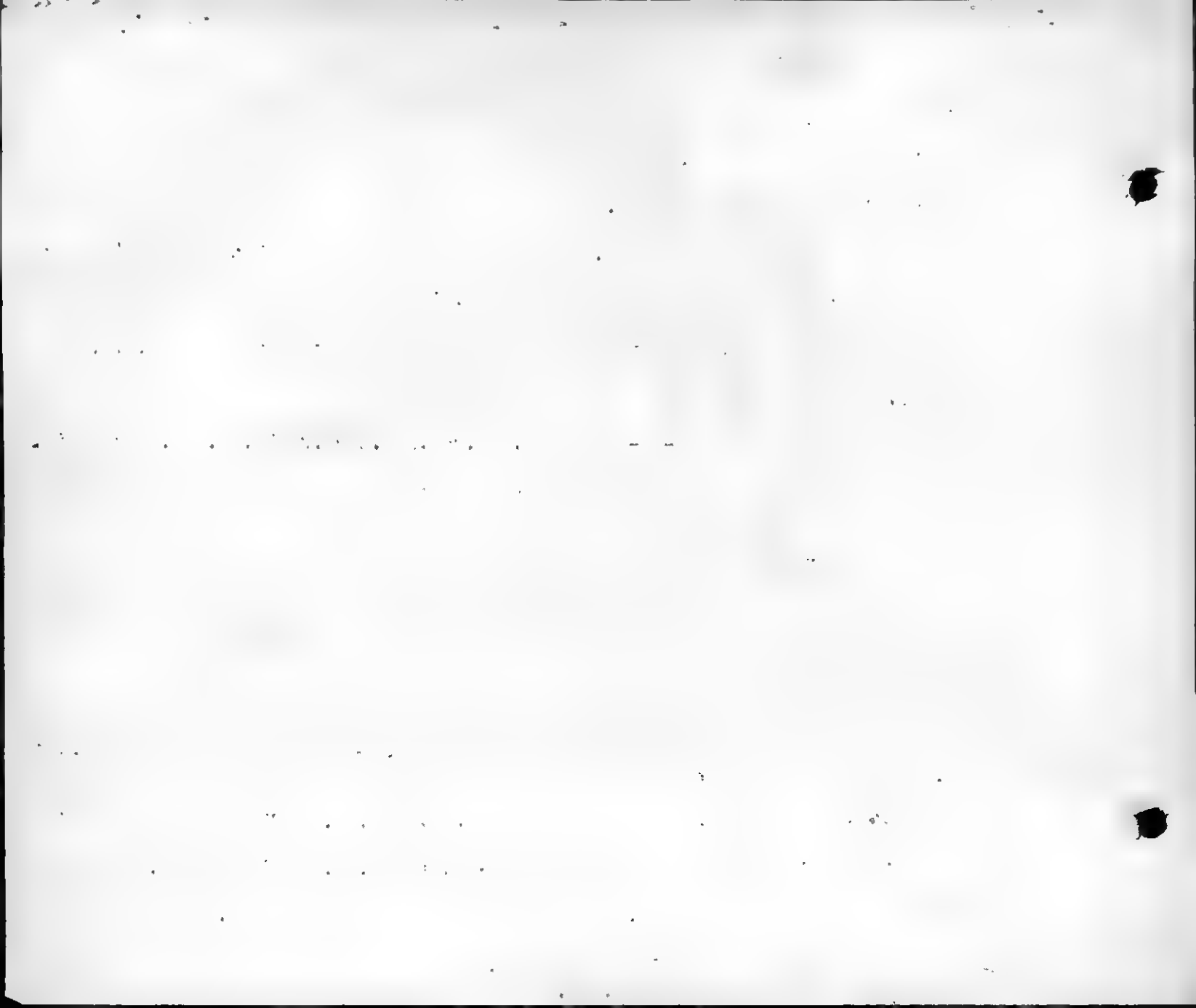
Reg. Dist. No.

13363

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 2 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 315 Orchard Avenue		
3. NAME OF DECEASED (Type or print) First HUGH Middle O. Last CARY			4. DATE OF DEATH Month December Day 31 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1908		9. AGE (In years lost birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager		10b. KIND OF BUSINESS OR INDUSTRY Super Market	11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward L. Cary			14. MOTHER'S MAIDEN NAME Mary Cary		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		16. SOCIAL SECURITY NO. 577-09-6736	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEMORRHAGIC PANCREATITIS 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SHOCK (c) EDEMA OF THE LUNGS			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 29, 1959 to December 31, 1959 , and that death occurred at 1:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Daniel A. Nieves		ADDRESS (Street, city or town, state) VAH, BALTO. MD. FT HOWARD DIV		DATE SIGNED 1/1/60	
PHYSICIAN'S NAME (Type) DANIEL A. NIEVES		VAH, BALTO. MD. FT HOWARD DIV.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-60	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Funeral Home		ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE JAN 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
Balto. Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13374

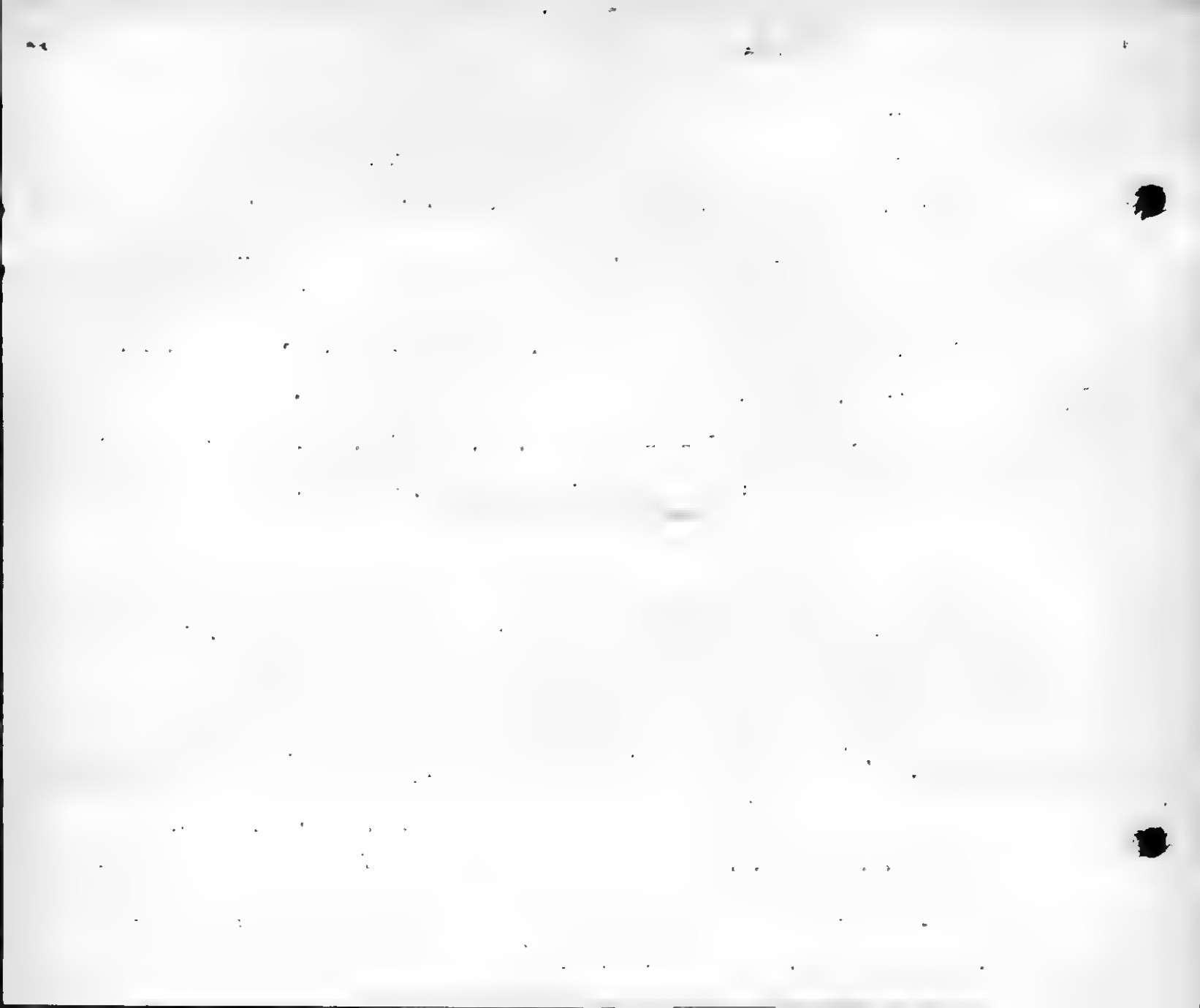
CERTIFICATE OF DEATH

Reg. Dist. No.

13340

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 57 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle L. Last CHARVAT		4. DATE OF DEATH Month DECEMBER Day 12 Year 1959	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/11
9 AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 3 Hours 1 Min 4	IF UNDER 24 HRS Hours 1 Min 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Off Set Pressman		10b. KIND OF BUSINESS OR INDUSTRY Lithographing Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Charvat		14. MOTHER'S MAIDEN NAME Catherine Duval	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-01-2549	
17. INFORMANT Clin. Rec. VAH, Balto., Md.		Address Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA PANCREAS WITH METASTASIS TO STOMACH, ADRENALS, SPINE AND LIVER Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) MURAL THROMBUS			INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH MYOCARDIAL INFARCTION AND/			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 16, 1959 , to December 12 1959 , that I am the deceased's physician, and that death occurred at 11:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. T.R. Hood		ADDRESS (Street, city or town, state) M.D. VAH, BALTO. MD. FORT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) T.R. HOOD, M.D.		DATE SIGNED VAH, BALTO, MD. FORT HOWARD DIVISION 12/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-17-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kline

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G253 12-28-59 et

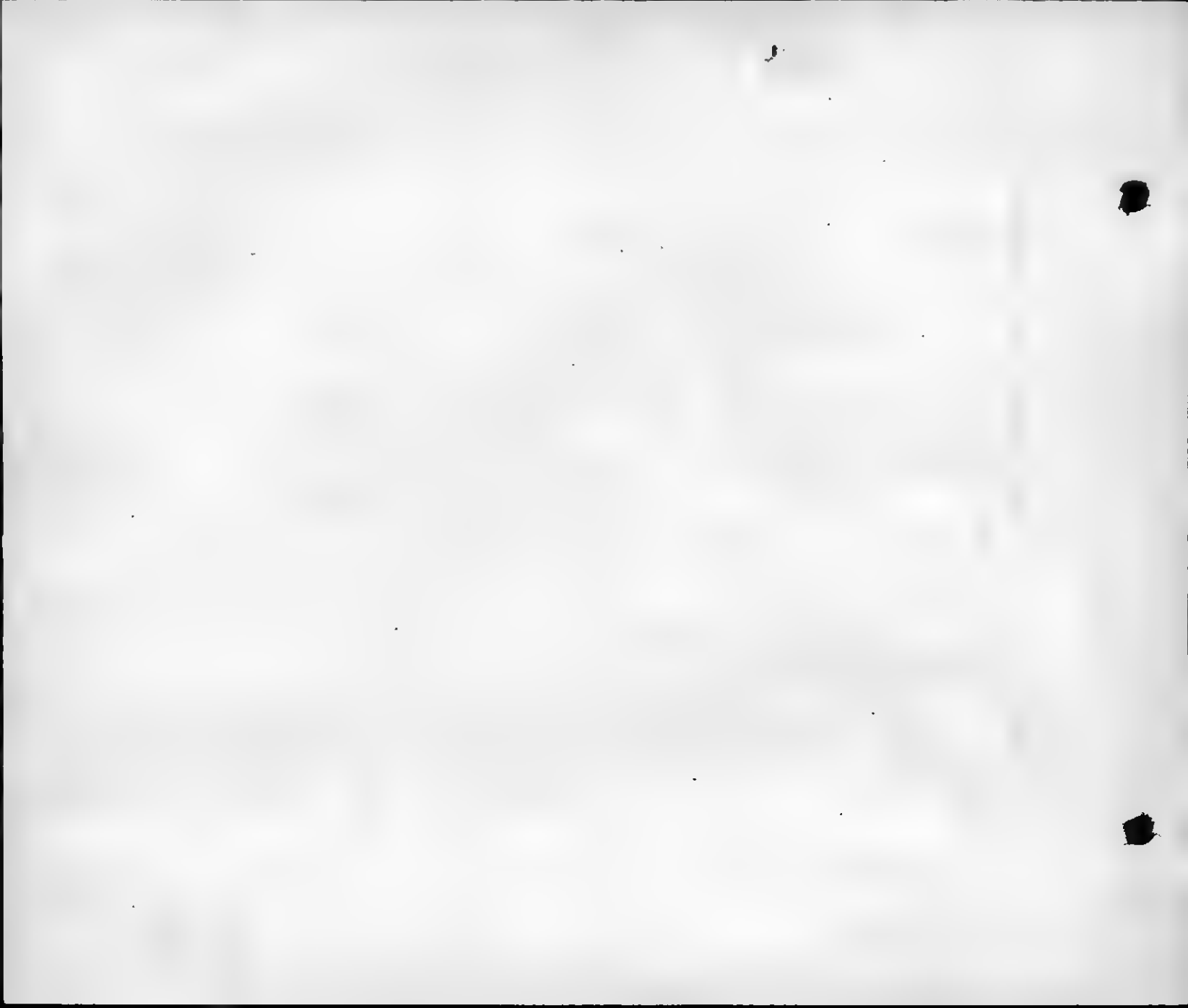
CERTIFICATE OF DEATH

Reg. Dist. No.

13341

13364

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)— a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9007 Simms</u>		d. STREET ADDRESS <u>9007 Simms Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John George</u> First <u>CHELOWETH</u> Middle <u>CHENOWETH</u> Last		4. DATE OF DEATH <u>Dec</u> Month <u>16</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18</u> 1872
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Bldg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ASBURY CHENOWETH</u>		14. MOTHER'S MAIDEN NAME <u>JANE SANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LESTER CHENOWETH</u> Address <u>2820 CHENOWETH AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion & Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5-10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Infarction (Convalescence)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Dec</u> Day <u>19</u> Year <u>59</u> Hour <u>a. m.</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>55</u> , to <u>Dec</u> 19 <u>59</u> , that I last saw the deceased alive on <u>12/19</u> 19 <u>59</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasir Jr.</u> M.D. <u>9005 Hartford Rd</u>		DATE SIGNED <u>12/16/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIR JR.</u>		<u>BALTO 14 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HISS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Road #6</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



13365

CERTIFICATE OF DEATH

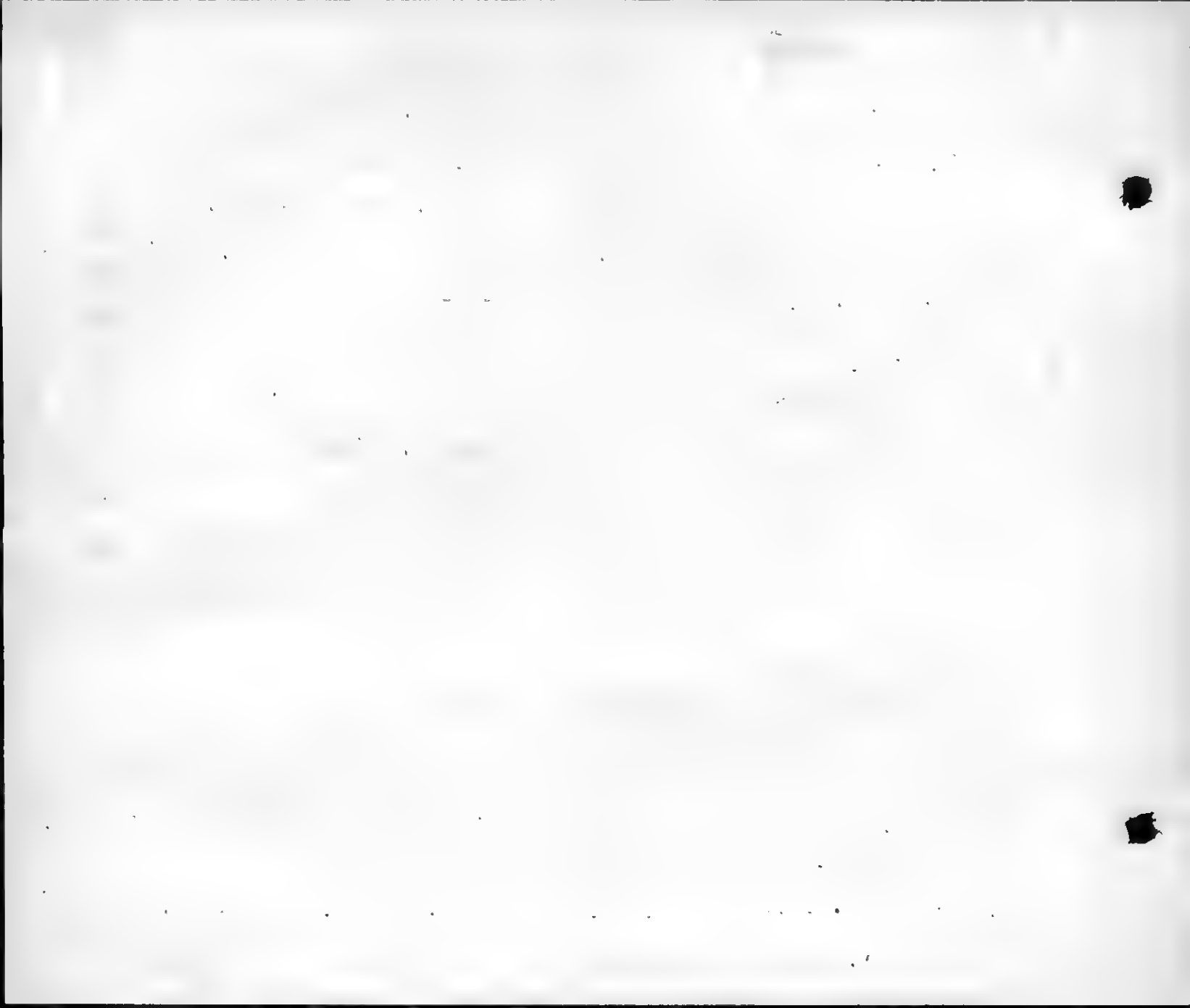
13342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 34-1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>822 E. Belvedere Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>(Mollie) Mary</i> First <i>E.</i> Middle <i>Clark</i> Last		4. DATE OF DEATH Month <i>Dec.</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-29-1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph O'Brien</i>		14. MOTHER'S MAIDEN NAME <i>Hopper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Willard R. Clark</i> Address <i>same</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinomatosis</i> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of stomach (removed Nov. 5, 1958)</i> (c) <i>Nov. 5, 1958</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct '54</i> 19, to <i>Dec 14</i> , 1959, that I last saw the deceased alive on <i>Dec 12</i> , 1959, and that death occurred at <i>8:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frederick J. Vollmer</i> M.D.		ADDRESS (Street, city and town, state) <i>6100 York Rd Balto + 2 Md</i> DATE SIGNED <i>12/15/59</i>	
PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER</i>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>12-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 17 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13366

Items 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

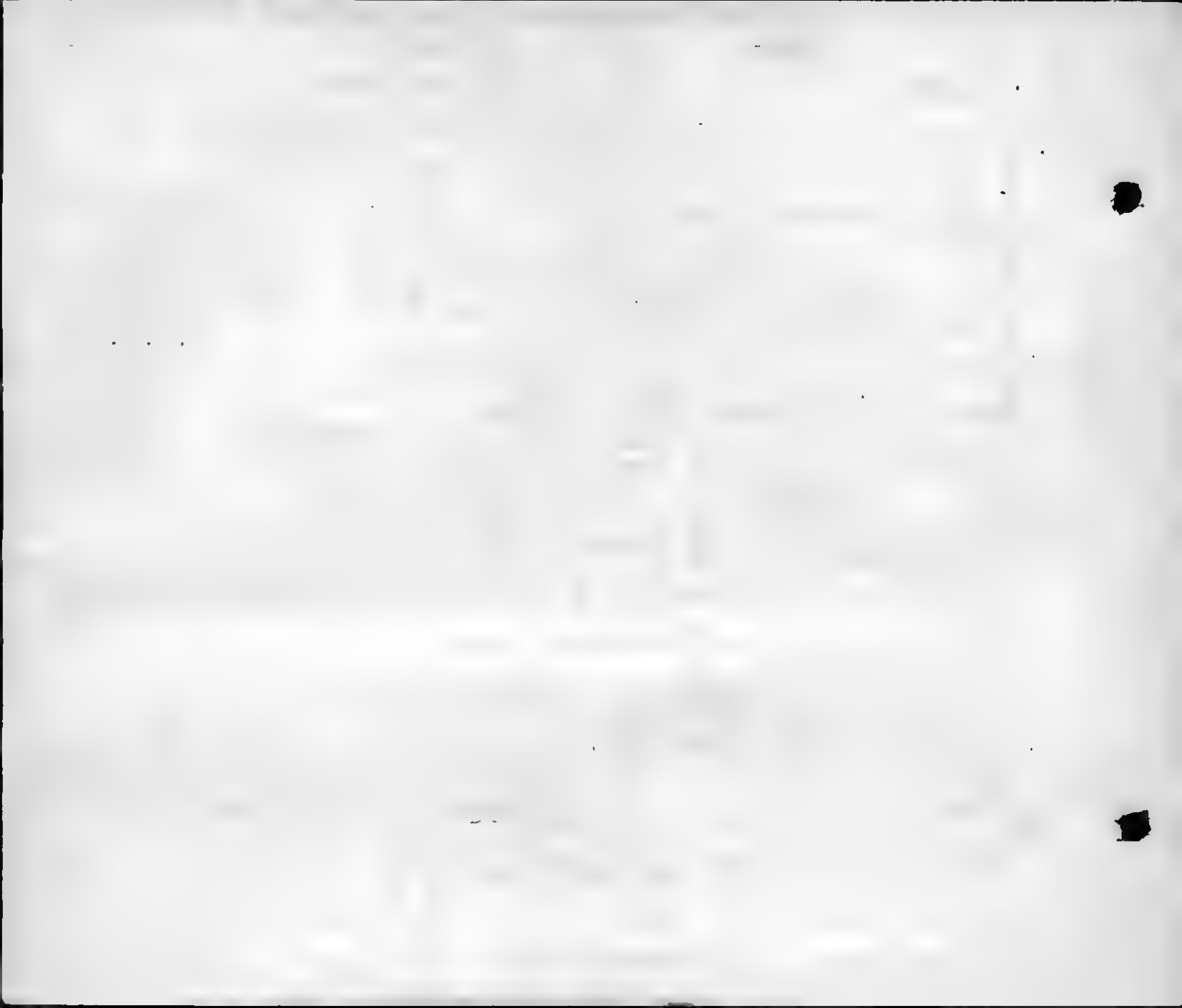
Reg. Dist. No.

13343

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1	
c. LENGTH OF STAY IN 1b 26r 7mth21dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2012 Robb Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Clayton Last Clayton		4. DATE OF DEATH Month December Day 12 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John F. Clayton		14. MOTHER'S MAIDEN NAME Sarah DeMoss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Atherosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 11 , 19 59 , to Dec. 12 , 19 59 , that I last saw the deceased alive on Dec. 11 , 19 59 , and that death occurred at 8:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE Edward J. Schinow M.D. PHYSICIAN'S NAME (Type) Catonsville 26, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/59	
22c. NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Fork, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home, Baltimore 6, Md.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13367 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13344

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2713 Waldor Drive</u>		e. STREET ADDRESS <u>2713 WALDOR DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>John Bramble</u> First Middle Last		4. DATE OF DEATH <u>Dec. 3 1959</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Bramble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>215-03-3209</u>	
17. INFORMANT <u>Winifred Truffer</u> Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:00 PM</u> , 19 <u>59</u> , to <u>3:00 PM</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 Dec</u> , 19 <u>59</u> , and that death occurred at <u>9:11</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
22b. DATE THEREOF <u>12-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kress</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13368
CERTIFICATE OF DEATH

13345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth8 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3112 Parkway Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Nancy Last Colegrove				4. DATE OF DEATH Month DEC. Day 27 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1866	
9. AGE (In years last birthday) 93 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) schoolteacher		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Orrin C. Bromwell				14. MOTHER'S MAIDEN NAME Rebecca Gilman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL DEBILITY DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 1 19 59 , to DEC 27 19 59 , that I last saw the deceased alive on Dec. 27 19 59 , and that death occurred at 12:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE P. K. Yip M.D. PHYSICIAN'S NAME (Type) P. K. Yip M.D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/59		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Crm., Pa		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Maenaw + Son Balto 28 ADDRESS BRACKEN FUNERAL HOME				24a. REC'D BY REGISTRAR DATE DEC 2 9 59		24b. REGISTRAR'S SIGNATURE Arthur S. Prank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

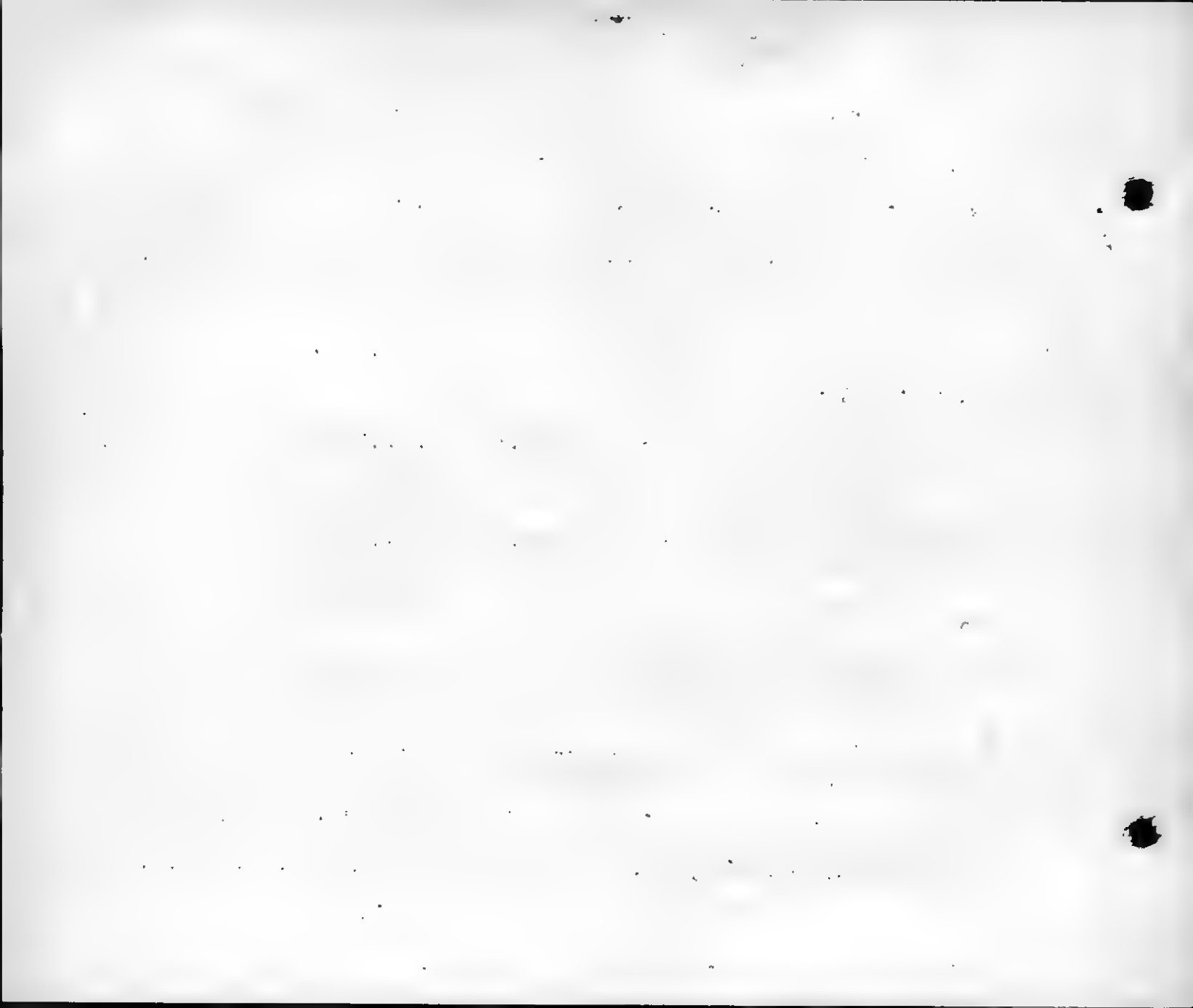
VS A15 (4)
ISM 9/58

1
13369
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

13346

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2V3; 4	
f. STREET ADDRESS 1208 McElderry Court		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle I. # Last COLLETT		4. DATE OF DEATH Month December Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1918
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herbert Collett		14. MOTHER'S MAIDEN NAME Rebecca Pratt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) II		16. SOCIAL SECURITY NO. 220-01-6763	
INFORMANT Clin. Rec. Vet. Adm. Hospital Balto 18, Md Ft. Howard		Address Division	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X EDEMA LUNGS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) HEMORRHAGE RIGHT FRONTAL LOBE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMATOUS BLEBS BOTH LUNGS		INTERVAL BETWEEN ONSET AND DEATH HOURS UNKNOWN	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 23, 19 59 to December 6, 19 59 and that death occurred at 1:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) VAH BALTO 18, MD FT HOWARD DIV	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 12/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR DEC 14 '59	
ADDRESS 1808 N Monroe St Balto 17, Md		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13370

CERTIFICATE OF DEATH

Reg. Dist. No.

10253

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN lb 15 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dogwood Road(Quaker Hill)		e. STREET ADDRESS Dogwood Road (Quaker Hill)	
3. NAME OF DECEASED (Type or print) First Anna Middle G. Last Crawford		4. DATE OF DEATH Month 12 Day 29 Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH Feb. 18, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dietrich Albers	
14. MOTHER'S MAIDEN NAME Helena Kuhlman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO 213-01-7677 B.		17. INFORMANT Mr. Karl W. Schaper	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - DUE TO Hypertensive C.V. disease - severe - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 years (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 6 , 19 55 , to Dec 29 , 19 59 , that I last saw the deceased alive on Dec 29 , 19 59 , and that death occurred at 11 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) 3601 Chapman Rd - 7 - BALTO 7 - MD	
PHYSICIAN'S NAME (Type) THOS. E. WHEELER		DATE SIGNED 12/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 1, 1960	22c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery	22d. LOCATION (City, town, or county) (State) Taylorville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE LORING BYERS		24a. REC'D BY REGISTRAR DATE JAN 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
ADDRESS 8728 Liberty Road Randallstown, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51

13371

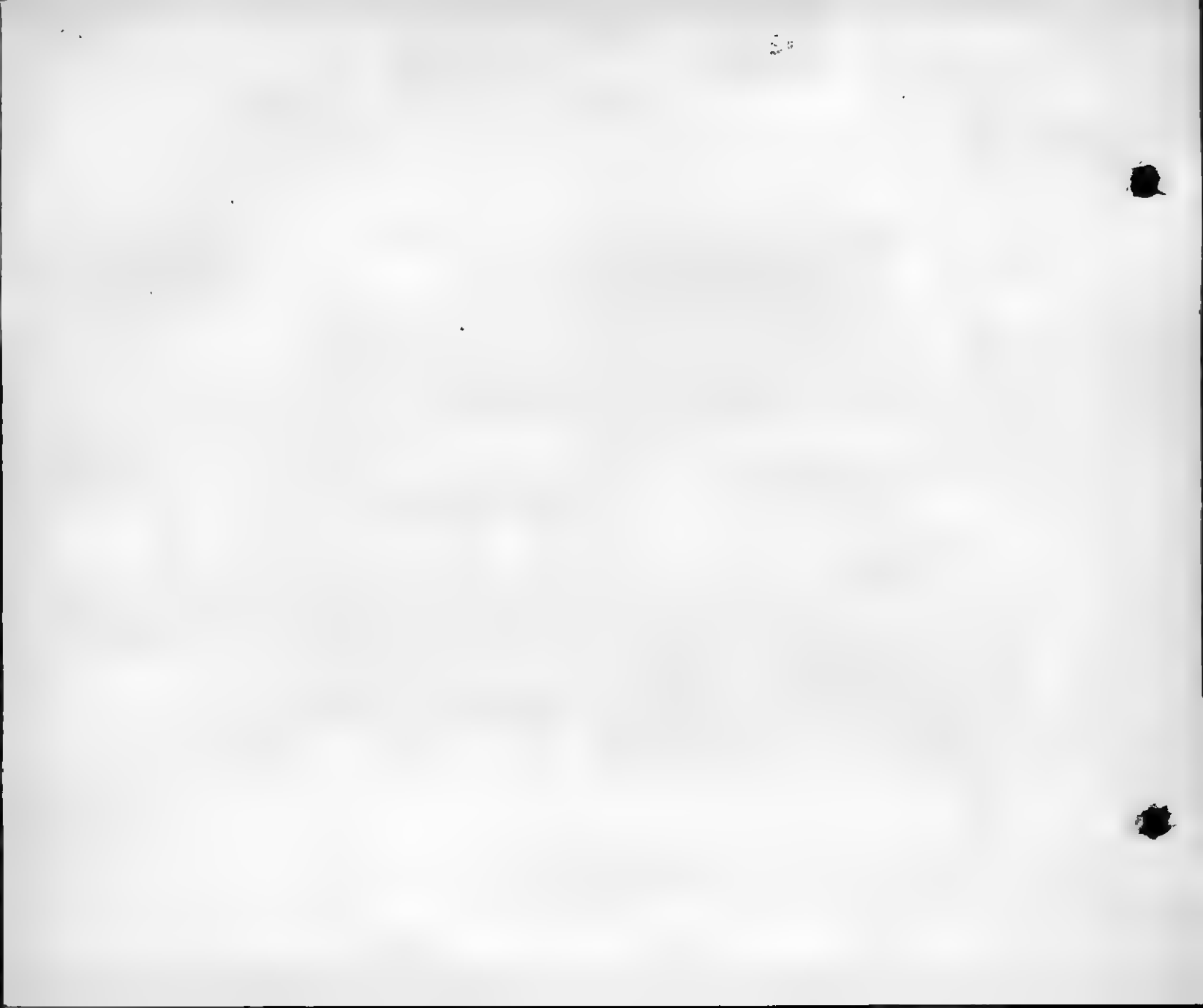
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>* PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3346 W. Loughby Rd</u>		d. STREET ADDRESS <u>3346 W. Loughby Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>John</u> Middle <u>Cross</u> Last <u>SR</u>		4. DATE OF DEATH <u>Dec</u> Month <u>7</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. L. Cross</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET LINDNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21-16-399</u>	
17. INFORMANT <u>Mamie V Cross</u>		Address <u>5141 C</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 5th</u> , 19 <u>59</u> , to <u>Dec 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. White</u>		ADDRESS (Street, city or town, state) <u>5214 Harford Rd, Balto.</u>	
PHYSICIAN'S NAME (Type) <u>James E. White M.D.</u>		DATE SIGNED <u>Dec 8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 11 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas T Evans & Son</u>		ADDRESS <u>8802 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>DEC 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford E. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13372
CERTIFICATE OF DEATH

13348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>60 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>305 Melancthon Ave.</u>				d. STREET ADDRESS <u>305 MELANCTHON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GWYNN</u> Middle <u>CROWTHER</u> Last <u>CROWTHER</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. BANKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FINANCIAL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>JOHN CROWTHER</u>				14. MOTHER'S MAIDEN NAME <u>WORTHENA HISS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-14-1065A</u>		17. INFORMANT <u>G. KENNETH CROWTHER</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>51.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic transitional cell carcinoma, bladder</u> DUE TO (c) <u>transitional cell carcinoma, bladder</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 months</u> <u>20 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Phonetic / American being for root name pain Sept. 1957.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> to <u>December, 1958</u> , that I last saw the deceased alive on <u>December 18, 1958</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>M.D. 1707 Notre Dame Dr Lutherville Md</u>					
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		DATE SIGNED <u>12-20-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & Sons Co.</u>				ADDRESS <u>4905 YORK RD, BALTO</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6254 1-4-60 et

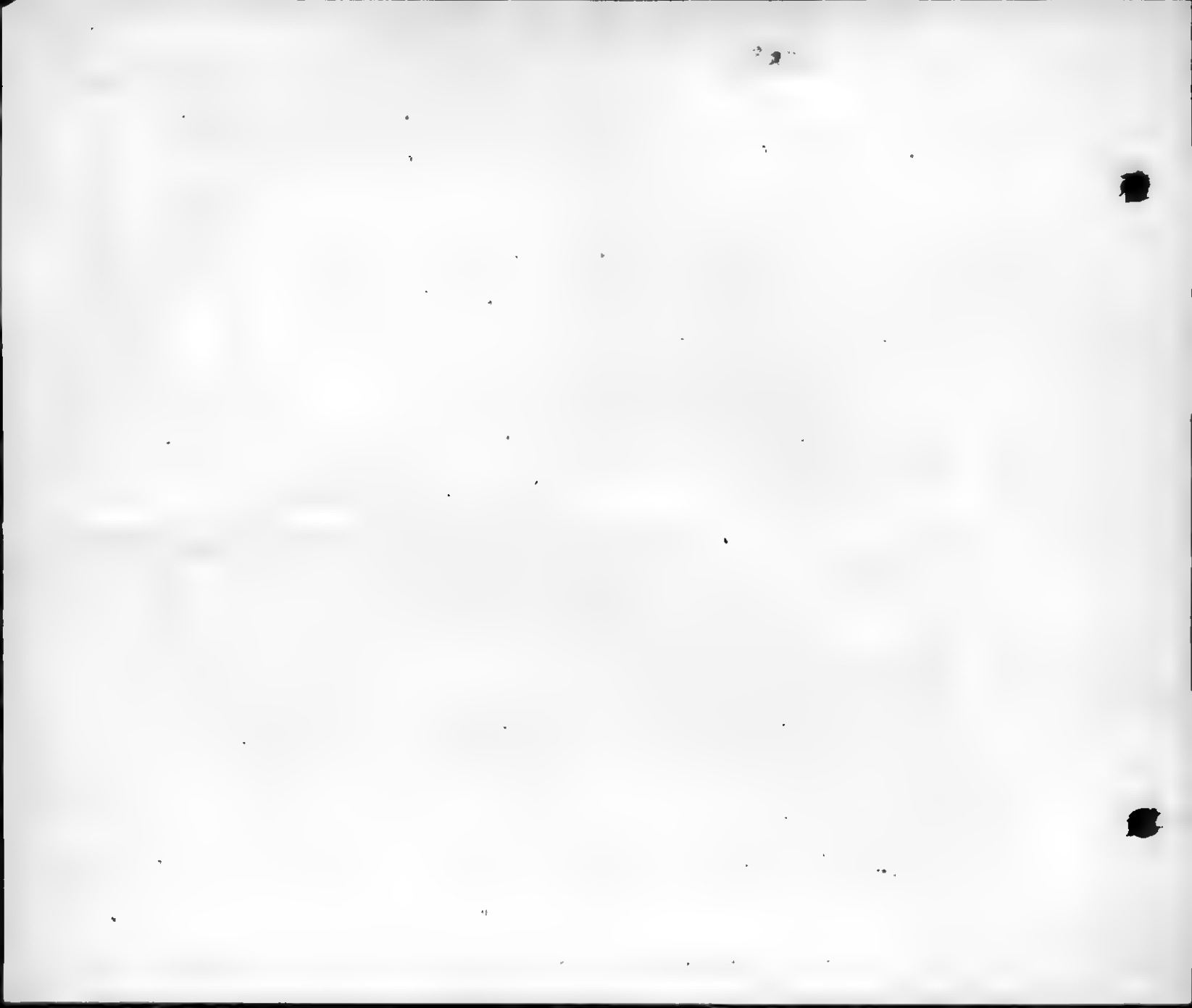
13373

CERTIFICATE OF DEATH

Reg. Dist. No.

13349

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Upperco</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Benson Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>R.</u> Last <u>Curtis</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Bruehl</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Ryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Mrs. Ernest Hale</u>		Address <u>Upperco, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u> DUE TO (c) <u>Diabetes 14 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u> <u>19 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes 14 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day Year Hour o. m. <u>None</u> p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-19, 1940</u> , to <u>12-25, 1959</u> , that I last saw the deceased alive on <u>12-23, 1959</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		ADDRESS (Street, city or town, state) <u>6 Hanover Rd. Reisterstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>D. D. CAPLES, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Butler Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u>		ADDRESS <u>Hampstead, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin L. Huns</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13350

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>219 Cornwood Ave</u>		e. STREET ADDRESS <u>219 Cornwood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>EDNA ELIZ. DAVISON</u>		4. DATE OF DEATH <u>Dec 31 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 11, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bradley A. Davison</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Monath</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Int.</u>	
17. INFORMANT <u>Henrietta Bottiger</u>		Address <u>219 Cornwood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Bronchitis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>4 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CARLTON</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuch</u> ADDRESS <u>5305 Hafford</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

DATE SIGNED
12-31-59



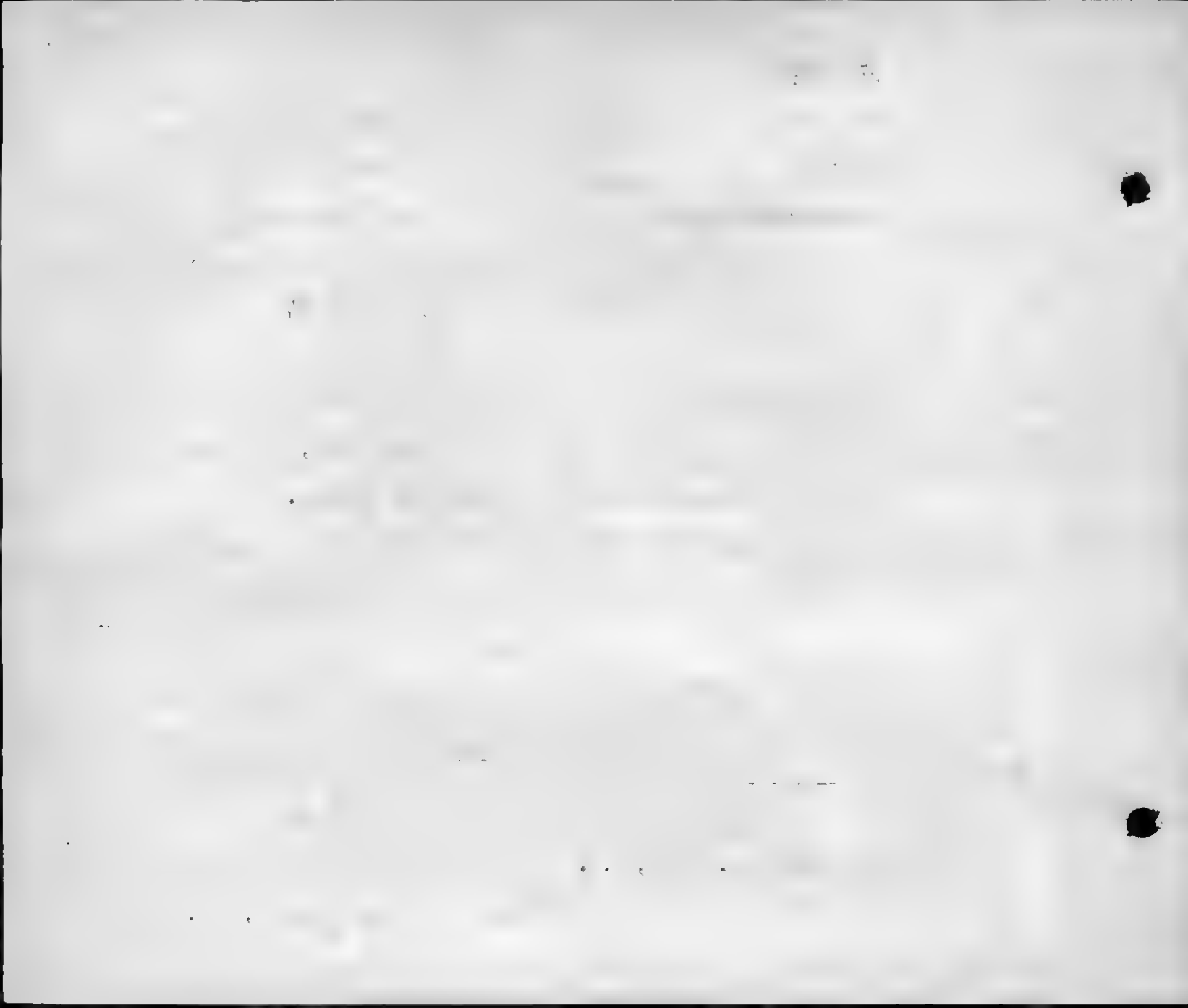
1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please write the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13375 13351											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosedale						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS 3717 Belair Road					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6600 Block Pulaski Highway						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANTONIO (ANTHONY) Di GUARDO						4. DATE OF DEATH December 5 19 59					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH April 11, 1882					
9. AGE (In years last birthday) 77 yrs						10. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener						10b. KIND OF BUSINESS OR INDUSTRY self-employed					
11. BIRTHPLACE (State or foreign country) Italy						12. CITIZEN OF WHAT COUNTRY? Italy					
13. FATHER'S NAME Salvatore DiGuardo						14. MOTHER'S MAIDEN NAME Ida Calvonara					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no						16. SOCIAL SECURITY NO. none					
17. INFORMANT Salvatore DiGuardo, son, 3124 Kentucky Ave						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty M.D.											
EXAMINER'S NAME (Type) Charles S. Petty, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment											
22b. DATE THEREOF 12/10/59											
22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum											
22d. LOCATION (City, town, or country) (State) Baltimore, Md.											
23. FUNERAL DIRECTOR ADDRESS Charles E. Schimunek Funeral Home 3331 Brehms Lane											
24a. REC'D BY REGISTRAR DEC 9 '59											
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus											



14378

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 219 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter First Michael Middle Doczkowski Last (Brother Fidelis Julian)				4. DATE OF DEATH Month Dec. Day 30 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/1884	
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brother				10b. KIND OF BUSINESS OR INDUSTRY Amundale Normal Inst.		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Viecent Dyczkowski				14. MOTHER'S MAIDEN NAME Anna Prejsksza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor pulmonale DOSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmanary tuberculosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 25 , 1959, to Dec 30 , 1959, that I last saw the deceased alive on Dec 30 , 1959, and that death occurred at 1:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Mt. Wilson, Maryland 12/30/1959							
ACTUAL SIGNATURE William Newcomer, M.D.				PHYSICIAN'S NAME (Type) Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/1960		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery Amundale Normal Institute, Amundale, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

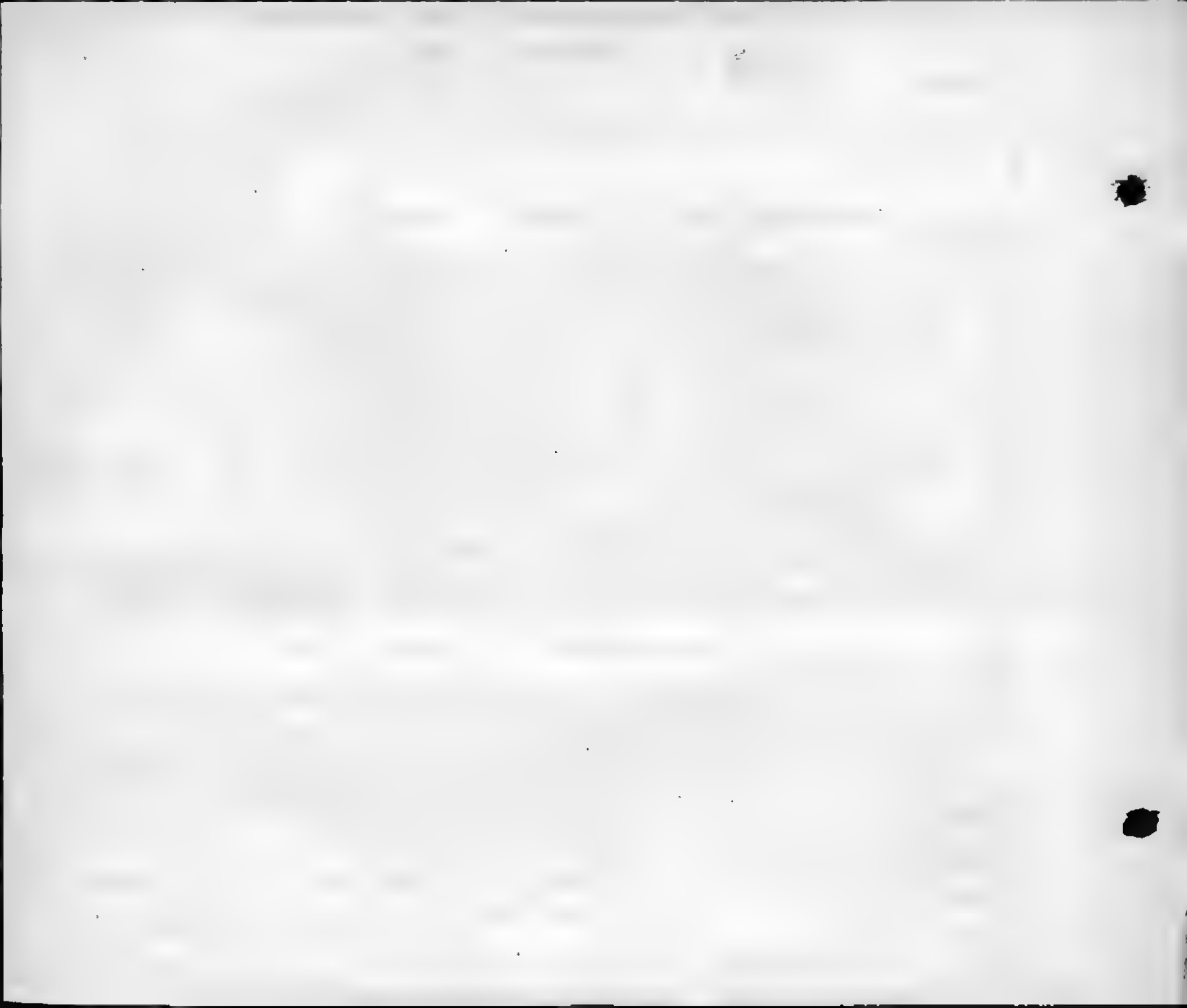
13377

CERTIFICATE OF DEATH

Reg. Dist. No.

13352

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Buffalo Run Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Catherine</u> Last <u>Dolly</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 October 1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Staiths West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Aaron Blaine Smith</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Alma Kessel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-9633</u>	
17. INFORMANT <u>Husband Mason Dolly</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 Dec</u> , 19 <u>59</u> , to <u>29 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		DATE SIGNED <u>Cockeysville, Md 29 December 1959</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dolly Family Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Old Field, West Virg.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 4 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13378

CERTIFICATE OF DEATH

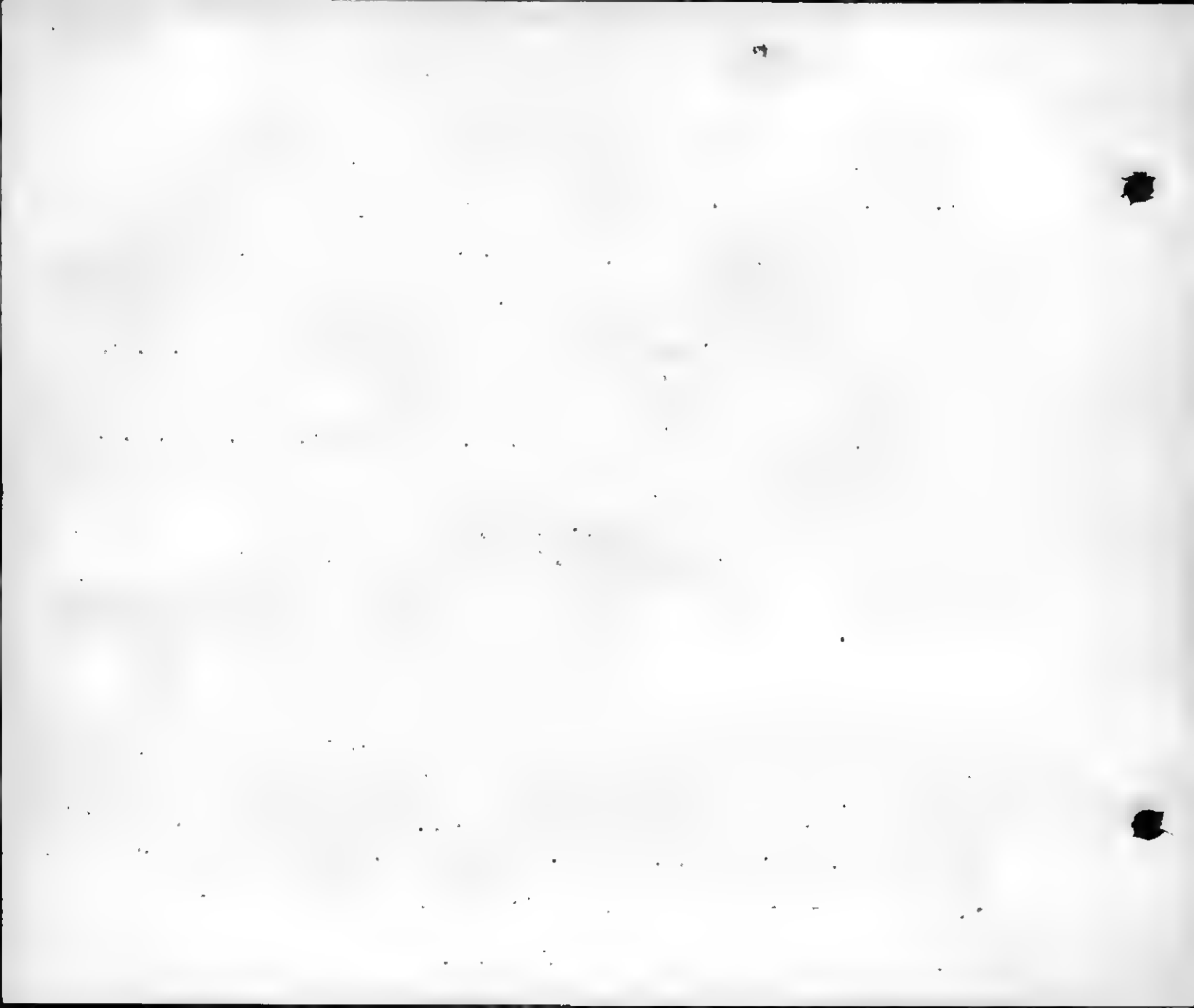
Reg. Dist. No.

13353

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY /	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle J. Last DORAN		4. DATE OF DEATH Month December Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawman		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	11. BIRTHPLACE (State or foreign country) Chester, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel Doran	
14. MOTHER'S MAIDEN NAME Clara Banks		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 213-07-7622		INFORMANT Clin. Rec., Vet. Adm. Hosp. Balto. 18, Md. Ft. Howard	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.4 EDEMA OF LUNGS DUE TO (b) CARDIAC DECOMPENSATION DUE TO (c) CARDIAC HYPERTROPHY, MITRAL INSUFFICIENCY AND DILATATION		INTERVAL BETWEEN ONSET AND DEATH Less than 1 day Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 5, 1959 to December 8, 1959 that I observed the deceased and that death occurred at 6:55 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, FT. HOWARD DIVISION BALTO. 18, MD 12/8/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO 18, MD. FORT HOWARD DIVISION 12/8/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda Funeral Home 7922 Wise Ave. Balto. Md.		24a. REC'D BY REGISTRAR DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Anthony L. Knead			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 20-21 Film 254 60 Items

13379

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13354

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville
c. LENGTH OF STAY IN b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3710 Milford Mill Road

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville
d. STREET ADDRESS 3716 Milford Mill Road

3. NAME OF DECEASED (Type or print) LANCE
4. DATE OF DEATH December 9, 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ DIVORCED ☐ WIDOWED ☐
8. DATE OF BIRTH May 9, 1945
9. AGE (In years last birthday) 14 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
11. BIRTHPLACE (State or foreign country) Balt.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Robert L. Doster
14. MOTHER'S MAIDEN NAME Vera M. Brushwood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. Robert L. Doster 3410 Croydon Rd. Balt. 7
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive hemorrhage due to gunshot wound of left chest
919.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot by friend
20c. TIME OF INJURY Month, Day, Year 6:25 p.m. 12 9 1959
20d. INJURY OCCURRED While ☐ at work ☒ Not While ☐ at work ☒
20e. PLACE OF INJURY (Home, farm, etc., street, office bldg., etc.) Home
20f. (City or town) Pikesville (County) Baltimore (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 12/10/59
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/12/59
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
22d. LOCATION (City, town, or country) Balt. Md.
23. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road Randallstown, Md.
24a. REC'D BY REGISTRAR DEC 17 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13380

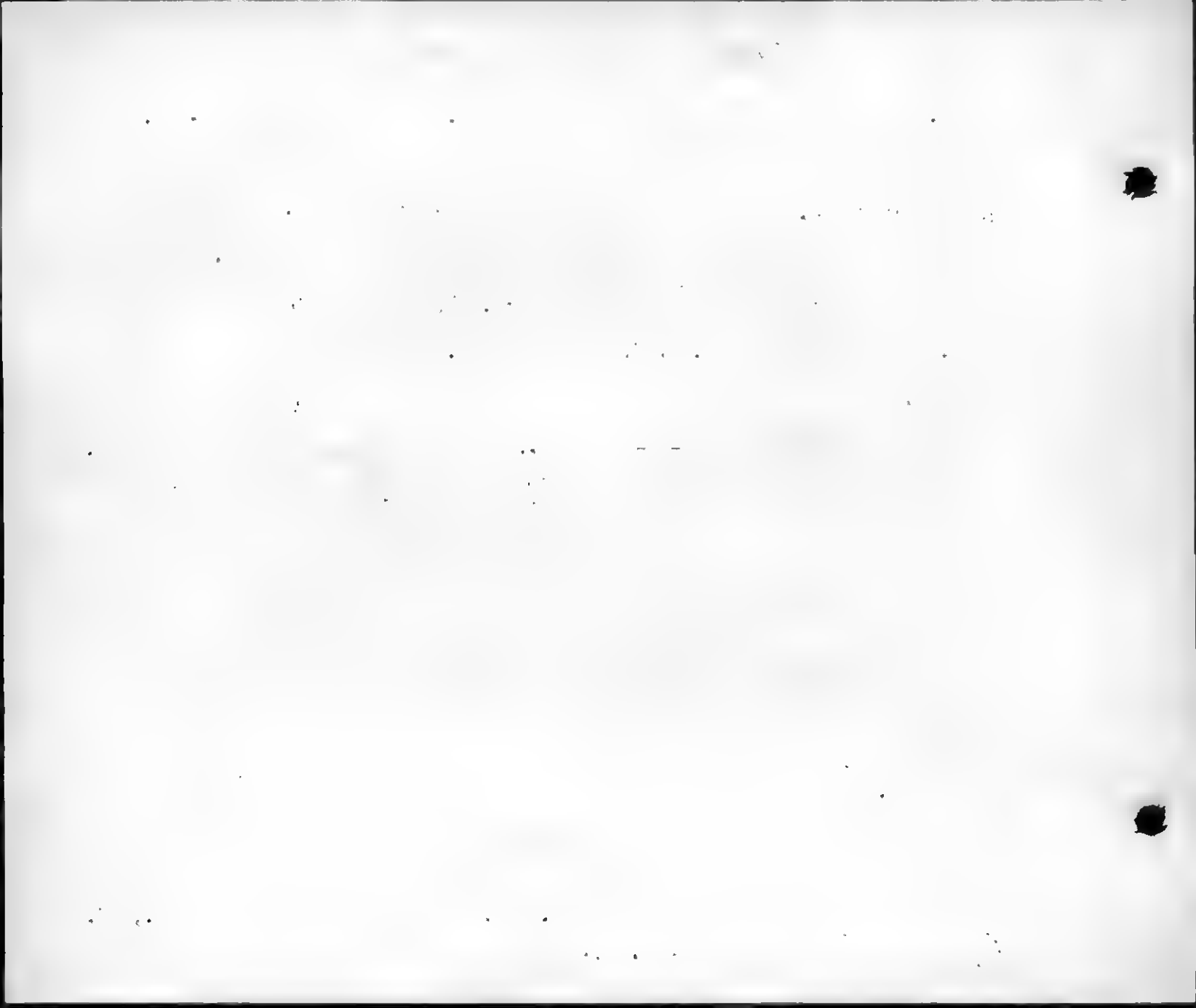
CERTIFICATE OF DEATH

Reg. Dist. No.

13355

1. PLACE OF DEATH a. COUNTY Balto.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7108 Bellona Ave.				d. STREET ADDRESS 7108 Bellona Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DONALD Middle HERBERT Last ENGLER				4. DATE OF DEATH Month Dec. Day 27 Year 19 59							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1903		9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Atty. & Supervisor				10b. KIND OF BUSINESS OR INDUSTRY U. S. F. & G.				11. BIRTHPLACE (State or foreign country) Md.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Emory E. Engler				14. MOTHER'S MAIDEN NAME Flora Jane Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 215-07-8736				INFORMANT Mrs. Kathareen Engler - 7108 Bellona Ave.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Arteriosclerosis (cardiovascular disease) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arterio sclerosis (cardiovascular disease) (c) arterio sclerosis (cardiovascular disease)				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that I attended the deceased from June , 1957, to Dec 27 , 1959, that I last saw the deceased alive on Dec 25/59 , 1959, and that death occurred at 8 AM , from the causes and on the date stated above.											
ACTUAL SIGNATURE Charles Tubitt				ADDRESS 4408 Oak Raven Blvd.				DATE SIGNED			
PHYSICIAN'S NAME (Type)											
22a. BURIAL CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/30/59				22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			
22d. LOCATION (City, town, or county) Balto., Md.				(State)							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Pickens & Sons - Balto 17				ADDRESS				24a. REC'D BY REGISTRAR DEC 28 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines											

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

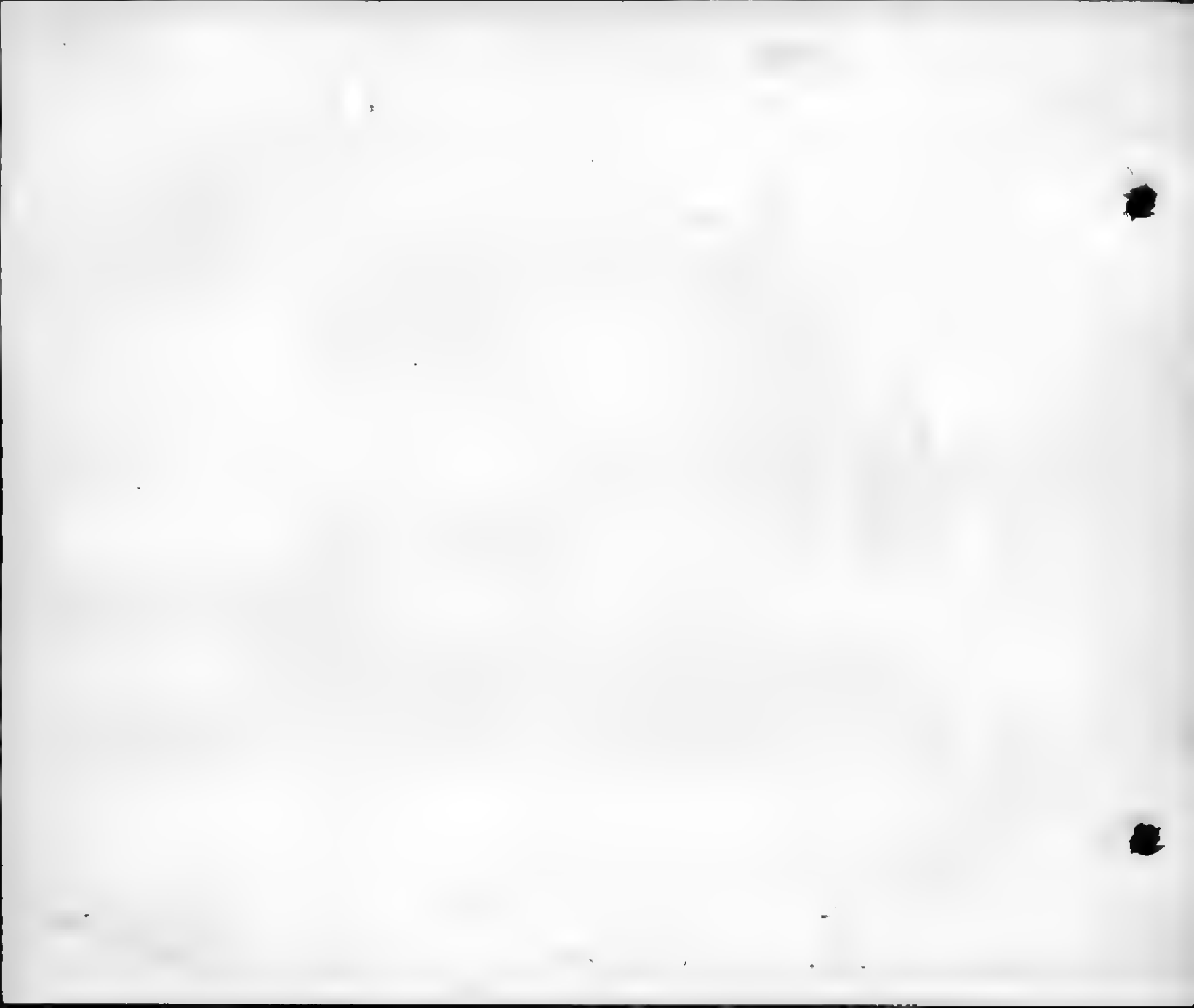
13381

CERTIFICATE OF DEATH

13356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>990 Aged Men's & Women's Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Leland Evans</u>		4. DATE OF DEATH <u>December 8, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs		10. IF UNDER 1 YEAR <u>3-27</u> Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hooper's Island, Dorchester Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>F. B. Leland</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Barclay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1-2-33-2-11-1</u>	
17. INFORMANT <u>Daisy E. Hammett</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebral Vascular Disease</u> <u>446x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>December 8, 1959</u> , that I last saw the deceased alive on <u>December 6, 1959</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland Edwards Day</u> M.D.		ADDRESS (Street, city or town, state) <u>4-2-33rd St - Balto</u>	
PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY MD</u>		DATE SIGNED <u>Dec 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS <u>1217 St. Paul Street</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



CERTIFICATE OF DEATH

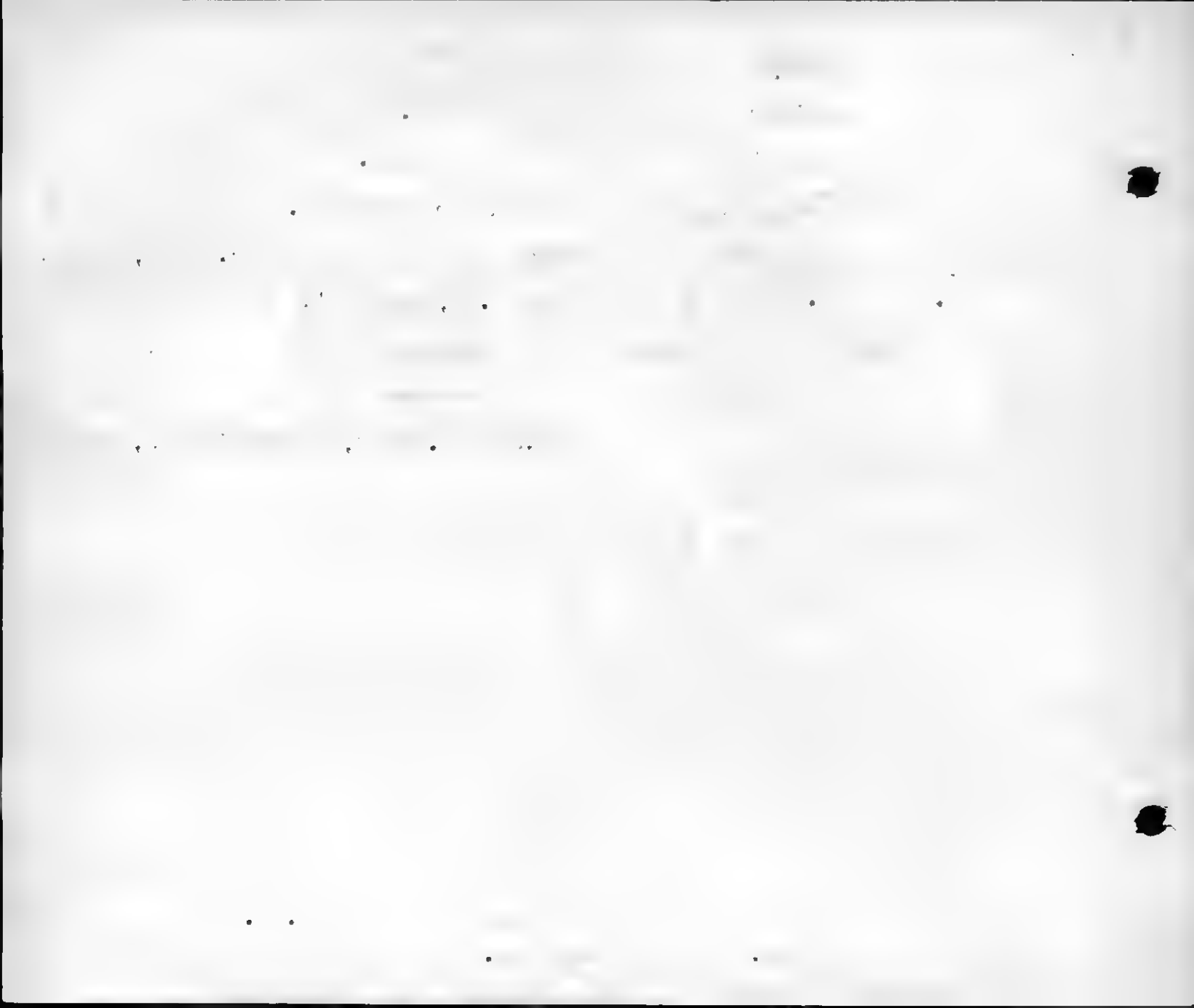
Reg. Dist. No.

13357

13382

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines 16 Fusting Ave				d. STREET ADDRESS 3549 Benzinger Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Elizabeth First Feher Middle Last				4. DATE OF DEATH Dec. Month 3, Day 19 Year 59			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Novak				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO.			
INFORMANT Mr. John F. Feher, 10 Overhill Rd, Catns 28				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Hypertensive Cardio-Vascular Disease DUE TO (c) 15 yr. INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-27-58 to 12-3-59 , that I last saw the deceased alive on 12-2-59 , and that death occurred at 10-AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Road Catonsville 28 Md. DATE SIGNED 12-3-59							
ACTUAL SIGNATURE Wilmer K. Gallagher				PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY London Park Centry	
22d. LOCATION (City, town, or county) Balto. Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DEC 4 '59		24b. REGISTRAR'S SIGNATURE William S. Kiser	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

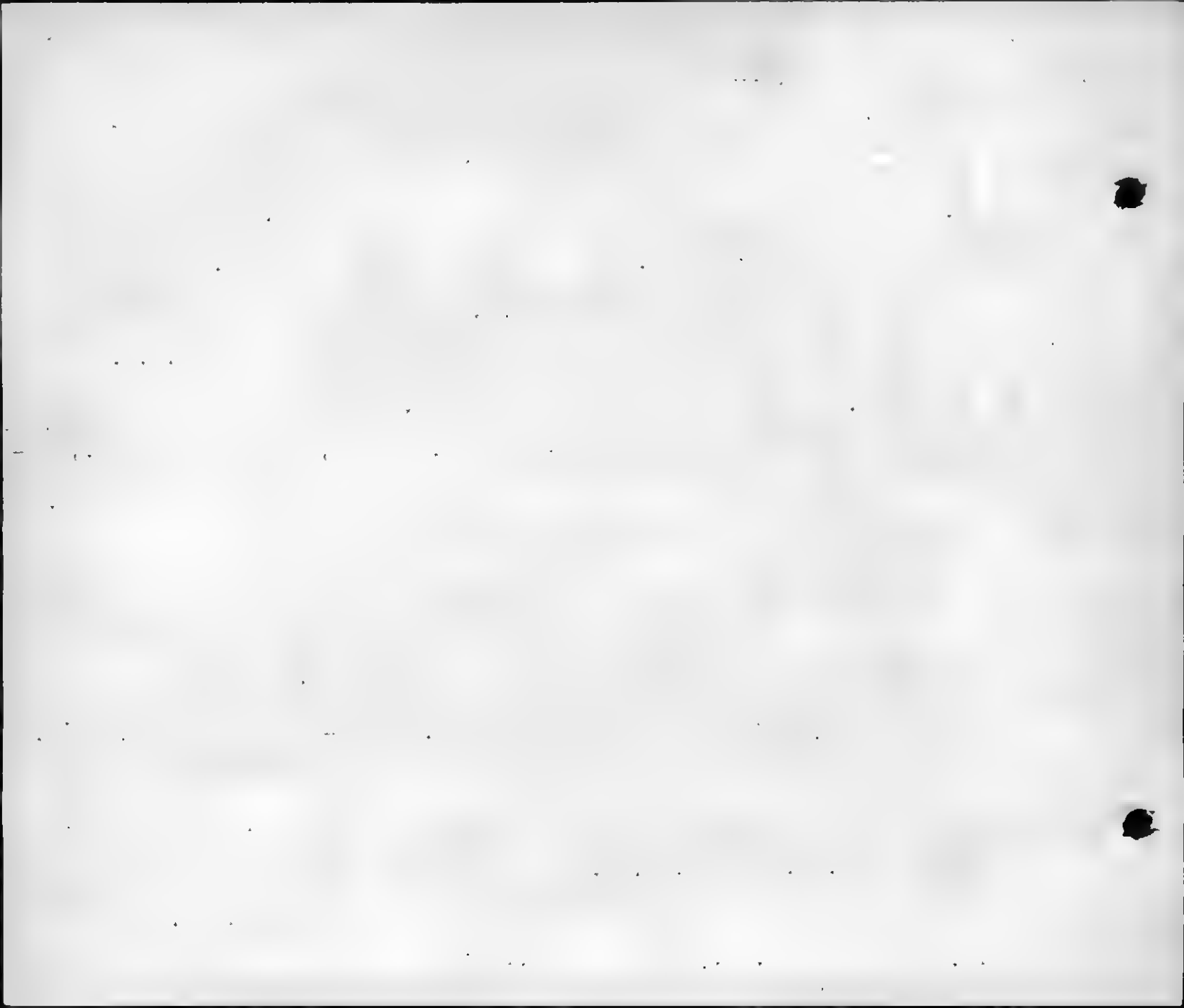
13358

13383

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklandville c. LENGTH OF STAY IN (b) student d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Paul's School		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton, 4 d. STREET ADDRESS 305 Greenwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linda M. Finley		4. DATE OF DEATH Dec. 7 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1947
9. AGE (In years last birthday) 12 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert M. Finley		14. MOTHER'S MAIDEN NAME Nancy Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Robert M. Finley		Address 305 Greenwood Rd., Ruxton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture base of skull with intercranial hemorrhage 15 min. 903.6 DUE TO (b) hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on flagstone patio at school.	
20c. TIME OF INJURY Month, Day, Year 4 Hour XX. Dec. 7 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) School-St. Paul's-Brooklandville, Balto.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		DATE SIGNED 12-8-59	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-59	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Son, Co., 4905 York Rd, Balto		24a. REC'D BY REGISTRAR DEC 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13359

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) # 4 EASTERN AVE.		d. STREET ADDRESS 139 RIVERSIDE RD.	
3. NAME OF DECEASED (Type or print) IDA T FISCHER		4. DATE OF DEATH DEC 25 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 19-1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) BALTO.		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME HUGH DEVINEY		14. MOTHER'S MAIDEN NAME KITTEY SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MYRTLE RUEDEL		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED None	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) BALTO. MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis MD		DATE SIGNED 12/29/59	
EXAMINER'S NAME (Type) M.B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/29/59	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly		24a. REC'D BY REGISTRAR —	
ADDRESS Essex 21 - Md.		24b. REGISTRAR'S SIGNATURE —	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13385

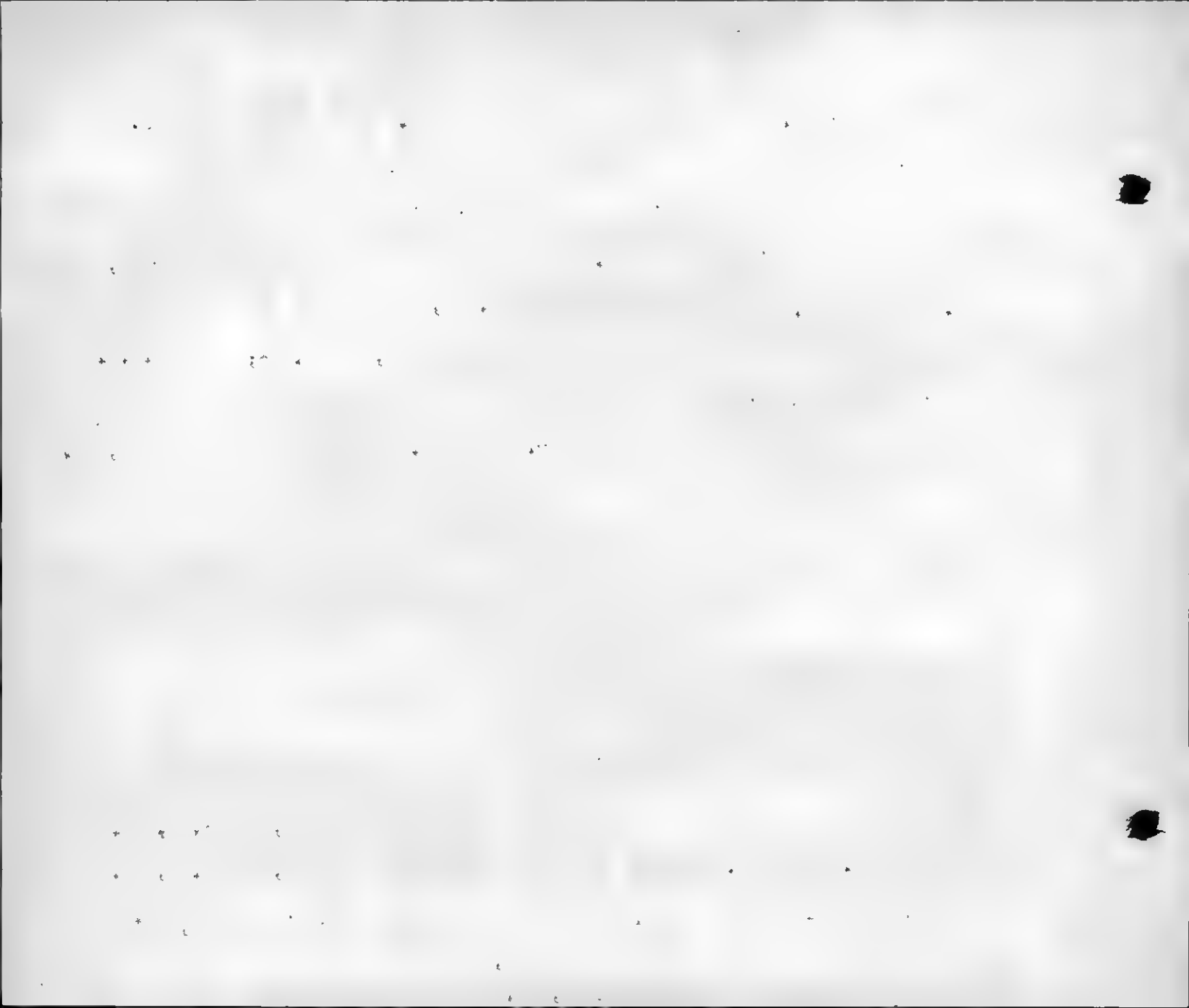
CERTIFICATE OF DEATH

13360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 60 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9119 Liberty Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kitty		4. DATE OF DEATH Monday December 14, 1959	
5. SEX F.	6. COLOR OR RACE W.	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1871
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Hernwood, Balto. Co;		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Edward Fite		14. MOTHER'S MAIDEN NAME Kato Mathews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Edward F. Stanfield		Address 9000 Church Rd Randallstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Severe generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. disease DUE TO (c) Hypertensive C.V. disease		INTERVAL BETWEEN ONSET AND DEATH 1.7 yrs 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 7, 1954 , to Dec. 14, 1959 , that I last saw the deceased alive on Dec. 14, 1959 , and that death occurred at 3:17 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) DATE SIGNED 3601 Clifmar Road, Balto. 7, Md.	
PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler		3601 Clifmar Road, Balto. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Paran Church Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LORING BYERS		ADDRESS 8728 Liberty Road, Randallstown, Md.	
24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13386

CERTIFICATE OF DEATH

Reg. Dist. No.

13361

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5yr5mth26dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Fitzpatrick</u> Last <u>1 DEC. 10 1959</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1892</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Martynn</u>				14. MOTHER'S MAIDEN NAME <u>Emma ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the bowel</u> <u>179</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Ascites</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>NOV 10 - Dec 10</u> <u>(one month)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	Month <u> </u> Day <u> </u> Year <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>November 7, 1959</u> , to <u>December 10, 1959</u> , that I last saw the deceased alive on <u>December 10, 1959</u> , and that death occurred at <u>6</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Loretta Hsu</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u> </u>					
PHYSICIAN'S NAME (Type) <u>Loretta Hsu, M.D.</u>		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>	<u>12-12-59</u>	<u>London PARK</u>		<u>BALTIMORE, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. J. Schwab</u> <u>Francis H. Miller</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



13387

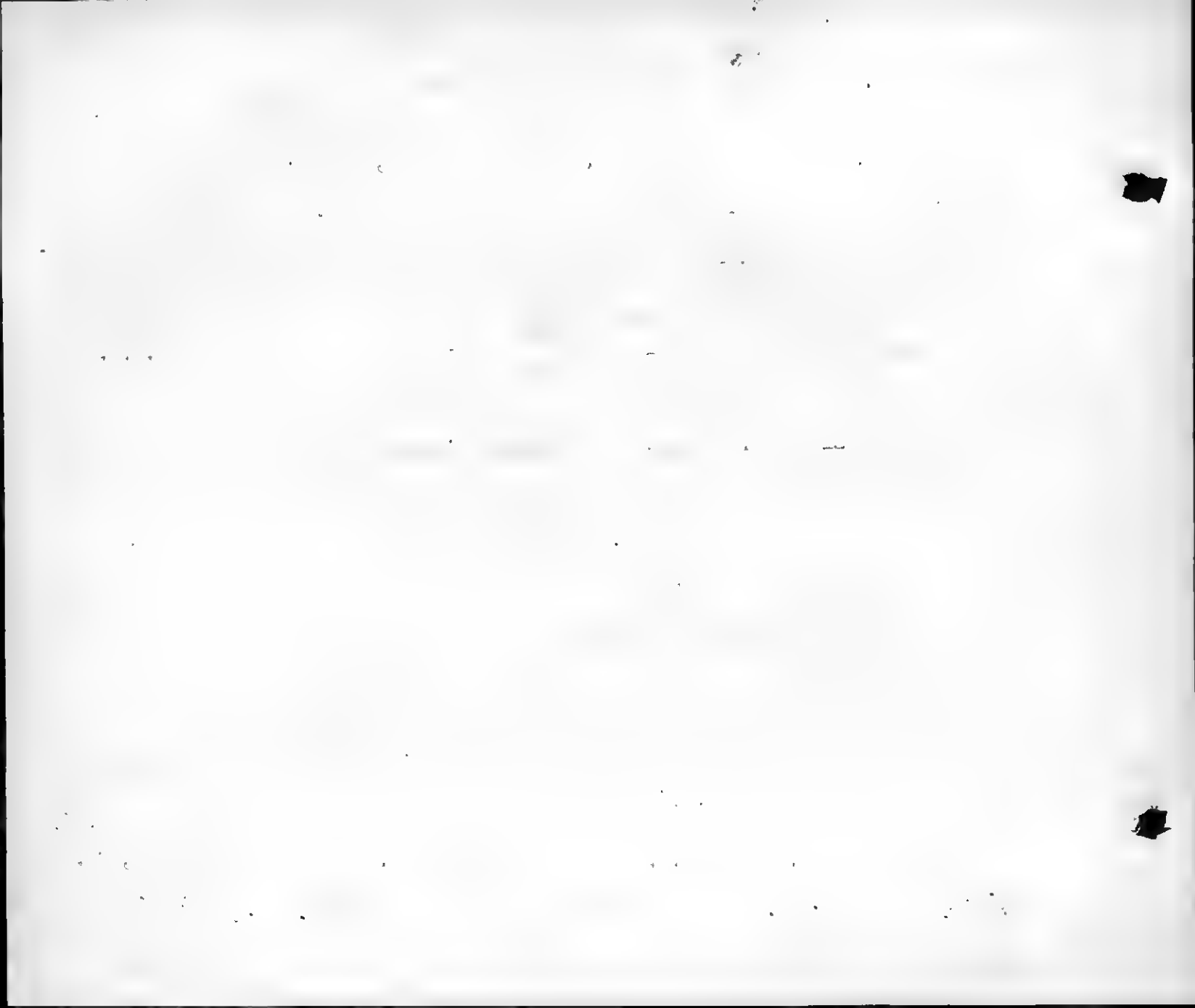
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓	
c. LENGTH OF STAY IN TB <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>723 Radnor Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Fleming</u> Last <u>Fleming</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/42</u>
9. AGE (In years last birthday) <u>17</u> yrs		10. IF UNDER 1 YEAR: Months <u>17</u> Days <u>16</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lonie Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Lonie Little</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelo-nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubitus Ulcers</u> DUE TO (c) <u>Epilepsy</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>1 1/2 years</u> <u>16 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Organic brain damage - birth</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/20/58</u> , 19 <u> </u> , to <u>12/16/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/16/59</u> , 19 <u> </u> , and that death occurred at <u>1:22p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest I. Decko</u> M.D.		ADDRESS (Street, city or town, state) <u>Rosewood</u> DATE SIGNED <u>12/18/59</u>	
PHYSICIAN'S NAME (Type) <u>Ernest I. Decko, M.D.</u>		Rosewood Tr. School, Owings Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>	22b. DATE THEREOF <u>12/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwald & Co</u>	22d. LOCATION (City, town, or county) (State) <u>Greenwald & Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Kate R. Williams</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>DEC 22 '59</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



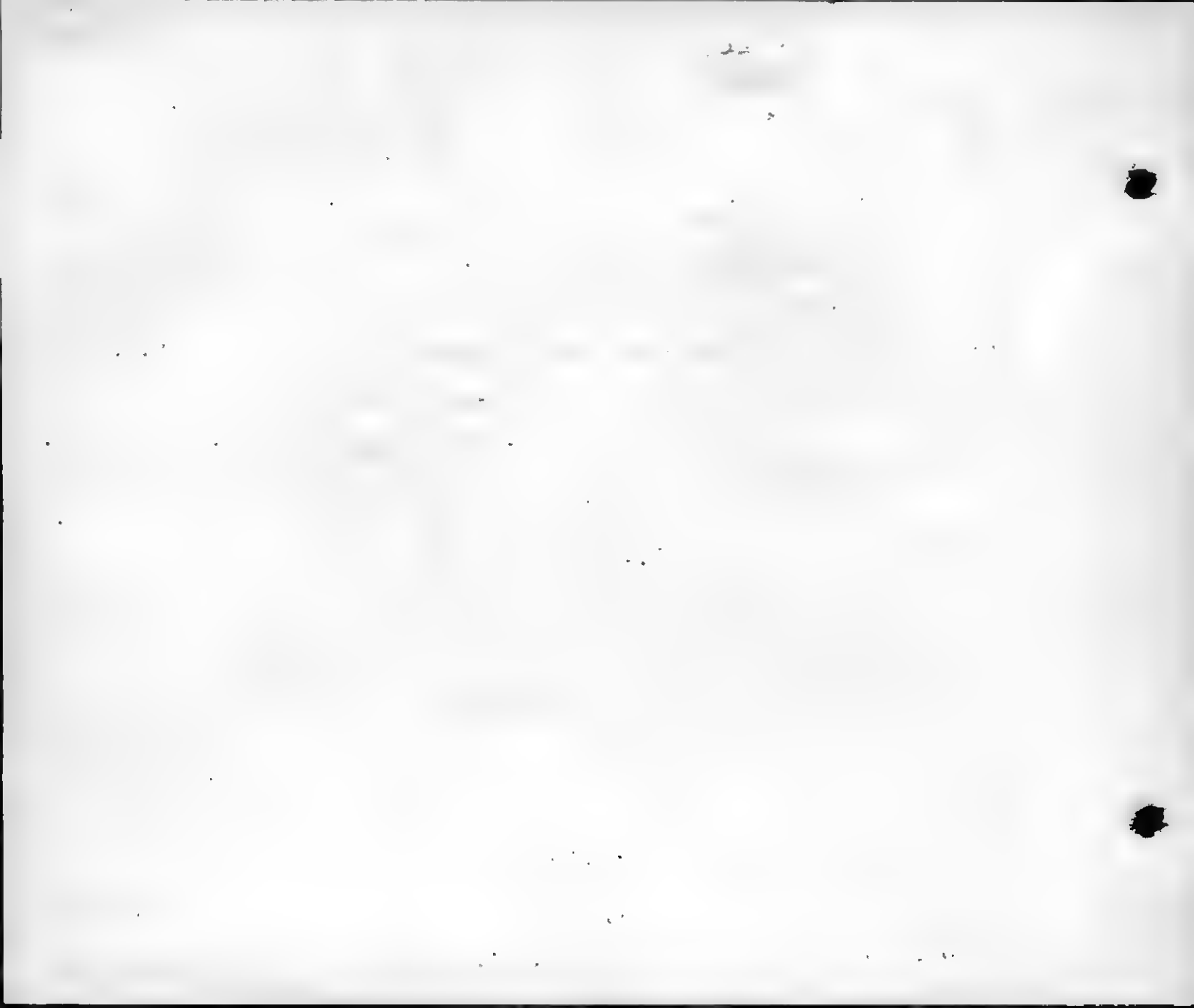
CERTIFICATE OF DEATH

Reg. Dist. No.

13363

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wilmar Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Ford, Sr.		4. DATE OF DEATH Month Day Year 12-29-59 JD	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1880
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Ford		14. MOTHER'S MAIDEN NAME Susan Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-5028	
17. INFORMANT Mrs. George H. Wirtz, Sr.		Address Wilmar Pl.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Failure - C DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1 , 1959, to Dec 29 , 1959, that I last saw the deceased alive on Dec 27 , 1959, and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T Gilmore, M.D. Lutherville, Md. 12/31/59			
ACTUAL SIGNATURE GEORGE T GILMORE		PHYSICIAN'S NAME (Type) GEORGE T GILMORE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-59	22c. NAME OF CEMETERY OR CREMATORY Poplar Grove	22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service		ADDRESS 622 York Rd. Towson 4, Md.	24a. REC'D BY REGISTRAR JAN 4 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13389

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY in lb 3yr11mth11days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 3610 Edgewood Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Mitchell Last Ford				4. DATE OF DEATH Month December Day 4 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1891 2 Apr. 10	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 215-05-5094		17. INFORMANT Records; SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 2 , 19 59 , to Dec. 4 , 19 59 , that I last saw the deceased alive on Dec. 4 , 19 59 , and that death occurred at 2:45 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-4-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elsworth Armacost				ADDRESS 4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraw							

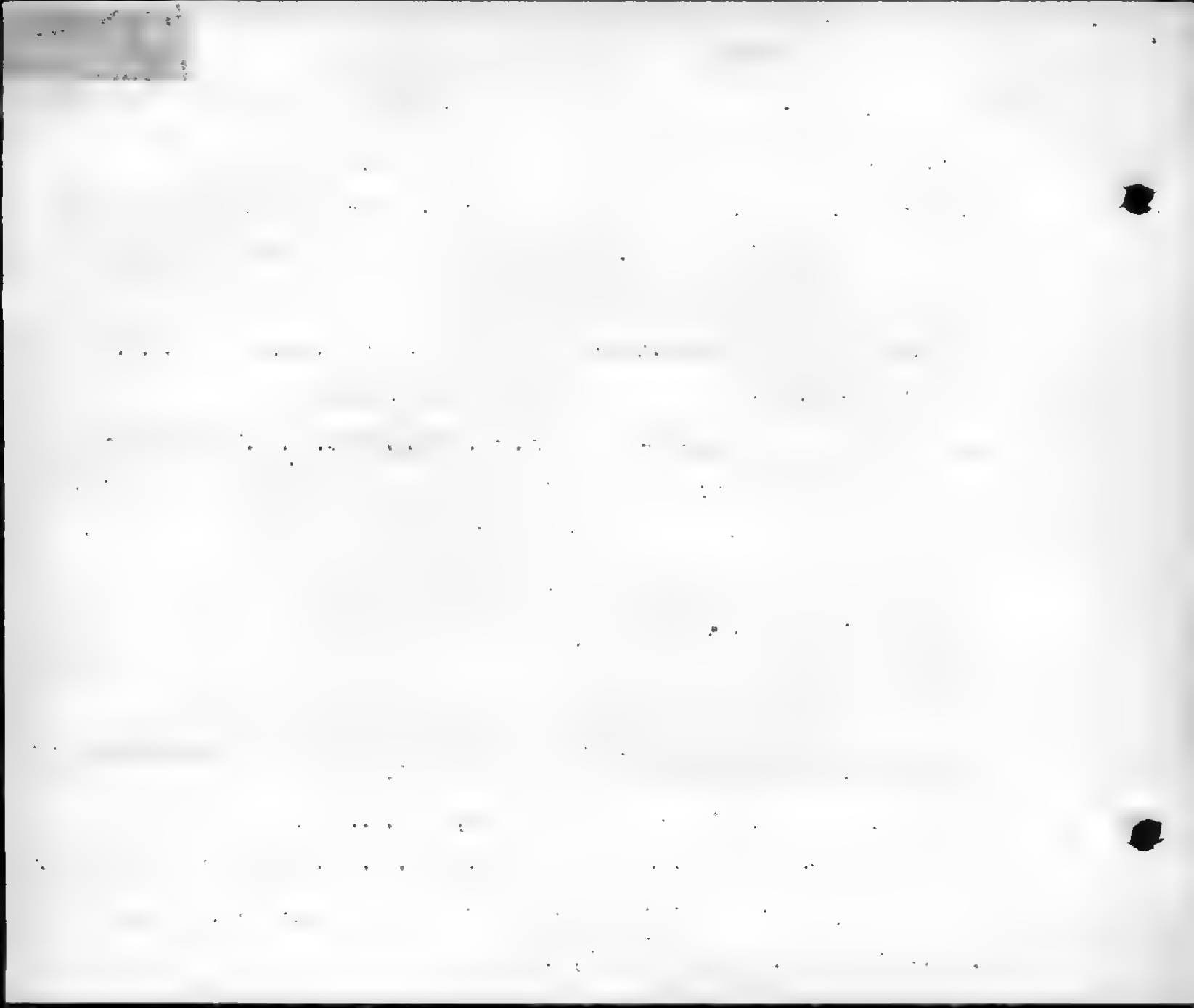
TO HOSPITAL—ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

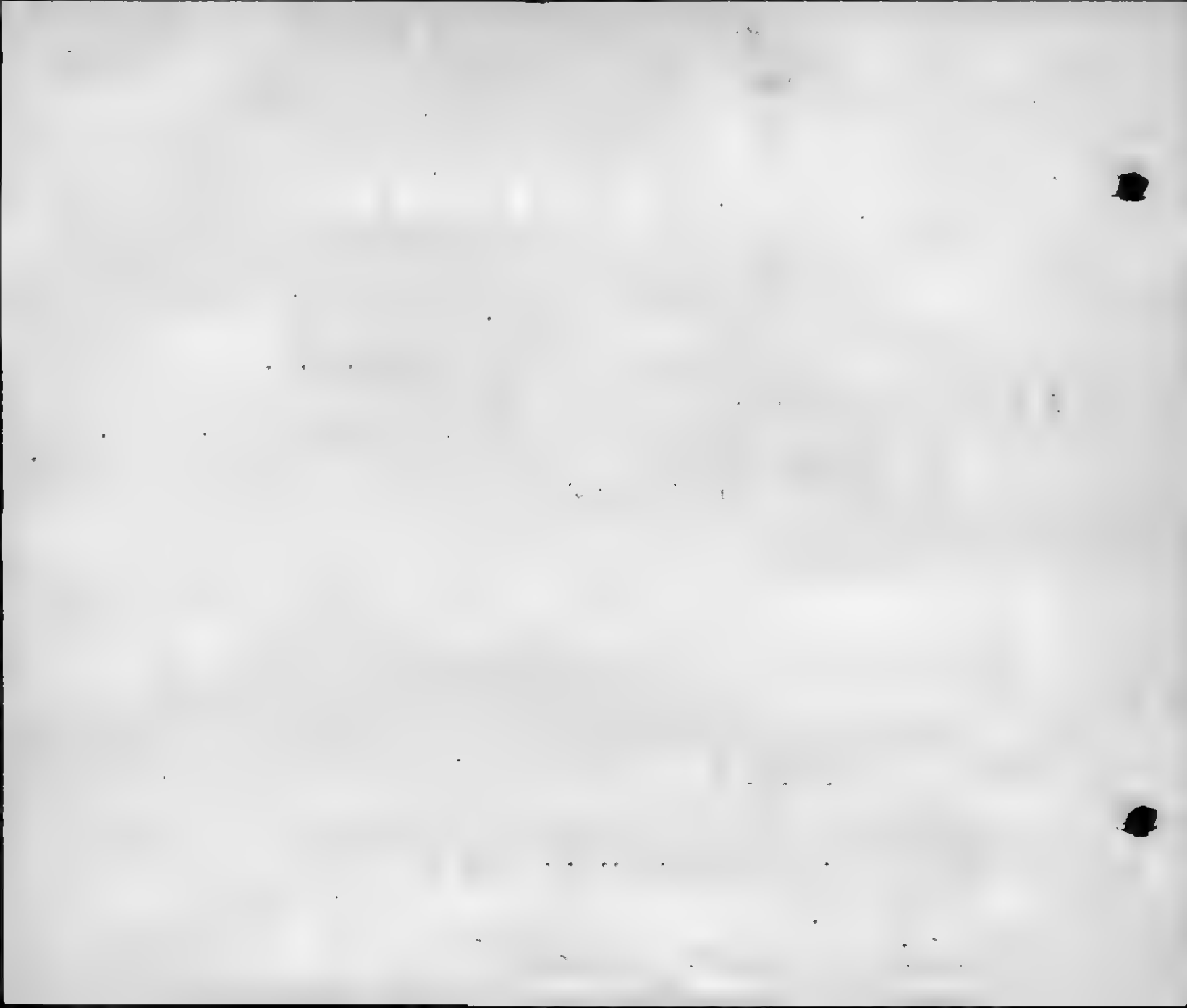
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

IVS AIS (4)
ISM 9/58





13392

CERTIFICATE OF DEATH

Reg. Dist. No. **13367**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CALIFORNIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE			c. LENGTH OF STAY IN TB 32 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURLOCK		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELI FOXALL				4. DATE OF DEATH Month Day Year 12 14 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-1980	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BENJAMIN FOXALL				14. MOTHER'S MAIDEN NAME PHOEBE BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT Address Frank R. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16, 1957 , to 12-14, 1959 , that I last saw the deceased alive on 12-14-1959 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. Arthur T. Keos ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 12/14/59 ACTUAL SIGNATURE M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12-16-159		22c. NAME OF CEMETERY OR CREMATORY Wiley Ford Cemetery		22d. LOCATION (City, town, or county) (State) Wiley Ford, West Va	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13393

CERTIFICATE OF DEATH

Reg. Dist. No.

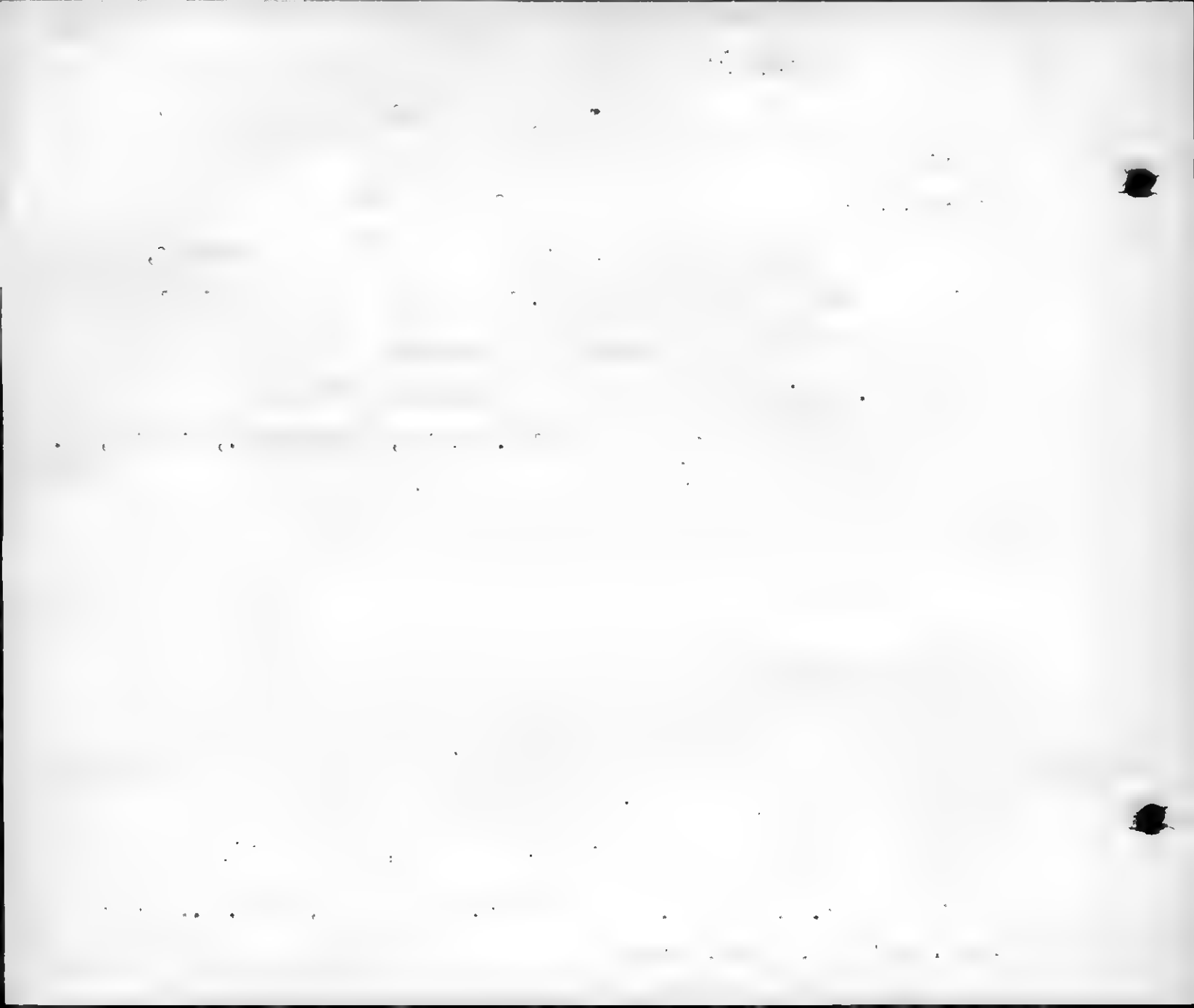
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Evans Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHAUN Middle FRAZIER Last 4. DATE OF DEATH Month December 3, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1959
9. AGE (In years lost birthday) yrs. 5 Months 15 Days 15 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby	
10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Paul F. Frazier		14. MOTHER'S MAIDEN NAME Marilyn Hawkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Paul F. Frazier, 23 Evans Ave., Timonium, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE DUE TO (b) ASTHMATIC BRONCHITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 2 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 2, 1959 to Dec 3, 1959 , that I last saw the deceased alive on Dec 2, 1959 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury M.D.		ADDRESS (Street, city or town, state) 2060 York Rd DATE SIGNED 12/4/59	
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY		Timonium, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	22d. LOCATION (City, town, or county) (State) Texas, Balto. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



13394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V-1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 509 GLEN ALLEN DRIVE	
3. NAME OF DECEASED (Type or print) First IRENE Middle T Last FREEDBURGER		4. DATE OF DEATH Month DEC Day 10 Year 1959	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 4, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARTIST		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME CARROLL S. FREEBURGER		14. MOTHER'S MAIDEN NAME MARY DERRINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-22, 1957 , to 12-9, 1959 , that I last saw the deceased alive on 12-9, 1959 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank L. Smith Jr.		DATE SIGNED 12/10/59	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Cockeysville, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-12-59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE DEC 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL AND ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13395

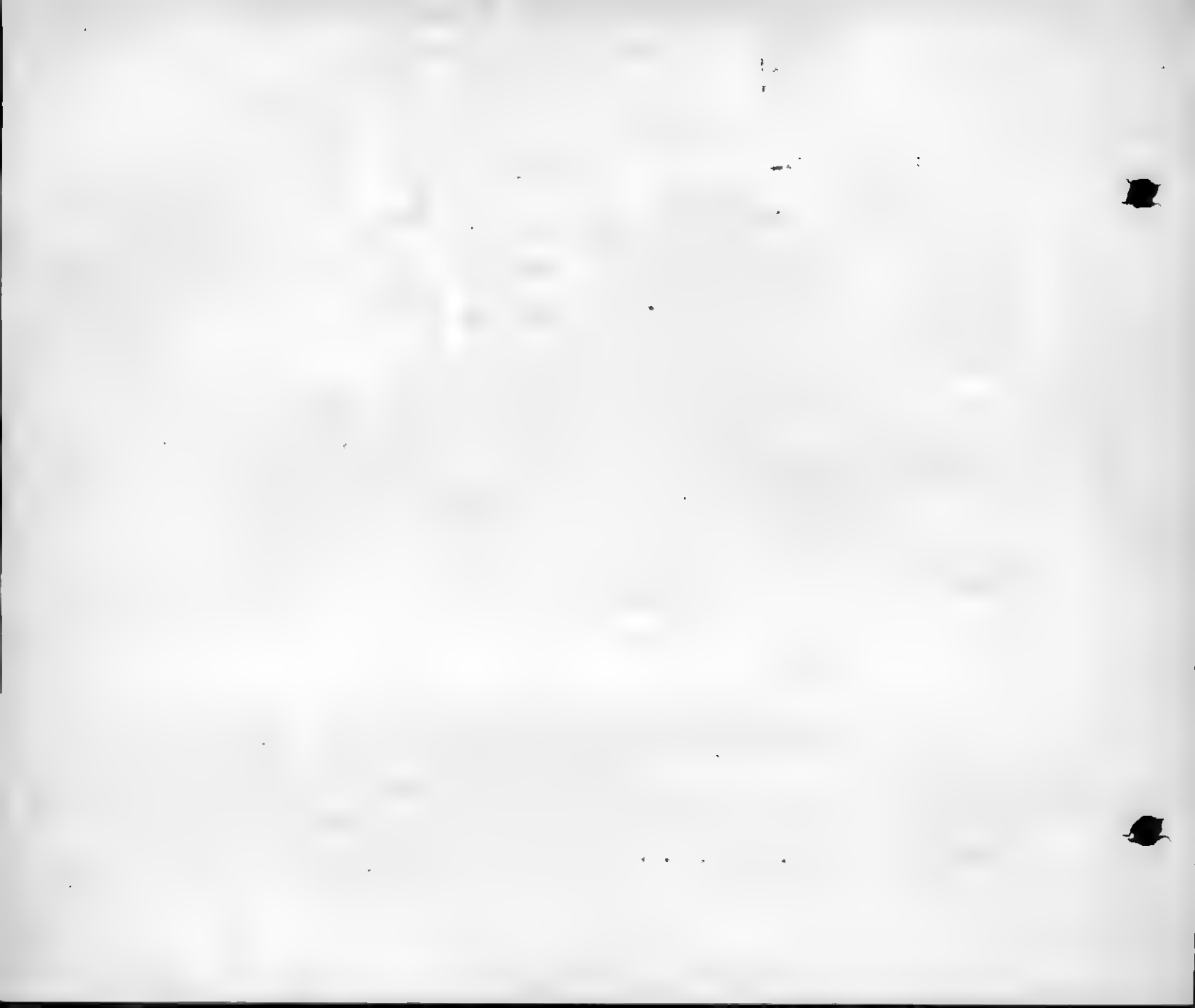
CERTIFICATE OF DEATH

13370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] o. STATE <u>MD</u> b. COUNTY <u>Cty.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>			c. LENGTH OF STAY IN 1b <u>4 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium</u> <u>Towson 4, Maryland</u>				d. STREET ADDRESS <u>925 E BALTIMORE ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Friedland</u> Last <u></u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/29/1907</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Abraham Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Dolcie Weinberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Personal History</u> <u>Hospital Records, Eudowood Sanatorium</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/8</u> , 19 <u>59</u> , to <u>12/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>59</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Eudowood Sanatorium</u> DATE/SIGNED <u>12/23/59</u>							
ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D.				PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Herring Run</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Green Lewis Inc</u>				ADDRESS <u>2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>				24c. LOCATION (City, town, or county) (State) <u>Balto MD</u>			

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

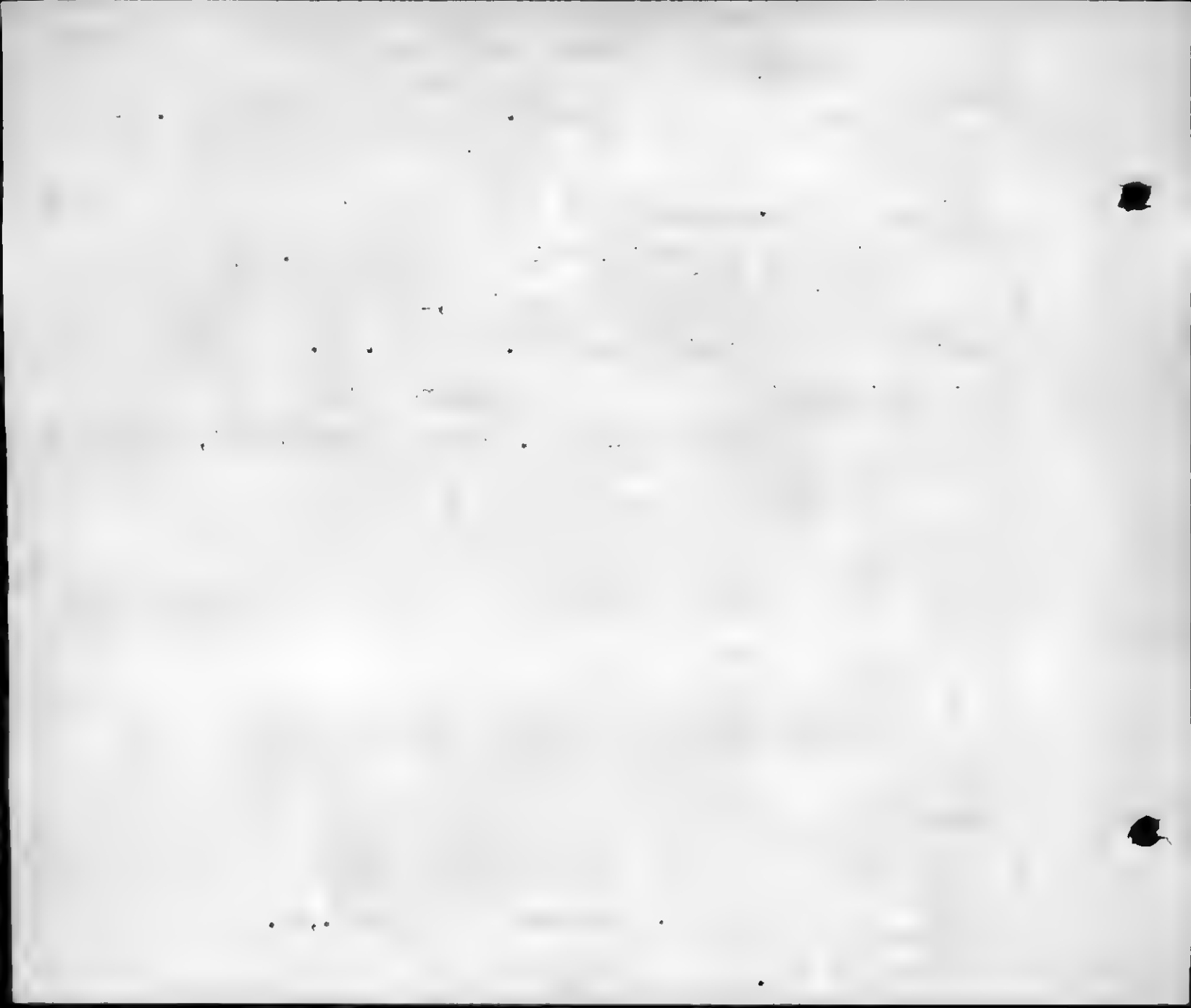
Reg. Dist. No.

13371

13395

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bendix Radio Corp. Jeppa Rd				d. STREET ADDRESS 623 Denison St			
3. NAME OF DECEASED (Type or print) First Richard Middle A Last Galiszewski				4. DATE OF DEATH Month Dec. Day 11 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1914	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 45 Days 19	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio Corp.		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Felix Galiszewski				14. MOTHER'S MAIDEN NAME Katherine Narnek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218 14 9293		17. INFORMANT Address St Mrs. Catherine Galiszewski, 623 Denison			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion +20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/11/59			
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Balto., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Mike Funeral Directors 4101 E. Amundson Ave.				24a. REC'D BY REGISTRAR DATE DEC 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13372

13397

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVELSCENT HOME				d. STREET ADDRESS 406 CENTRAL AVENUE			
3. NAME OF DECEASED (Type or print) First HARMON Middle PAUL Last GESSFORD				4. DATE OF DEATH Month DECEMBER Day 23 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 APRIL 1902	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER				10b. KIND OF BUSINESS OR INDUSTRY SOUTHERN FUEL CORP.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME PAUL GESSFORD				14. MOTHER'S MAIDEN NAME ALICE PRYOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 219-14-3607			
17. INFORMANT MRS. ELIZABETH W. GESSFORD				Address 406 CENTRAL AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>Dec 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert T. Parker M.D.</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 26 DEC. 59		22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) TOWSON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Burns Son's</u>				ADDRESS <u>Loveton Md.</u>		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

701-1-21

13330

CERTIFICATE OF DEATH

Reg. Dist. No.

13373

1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1904 JACKSON RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WILLIAM GETZ		4. DATE OF DEATH DEC. 20 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY PENNA. RAILROAD	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN GETZ		14. MOTHER'S MAIDEN NAME LOUISA WIEGAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 717-07-7196	
17. INFORMANT MRS. MARG. MAY GETZ		Address 1904 JACKSON RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain cancer, primary 173.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of rectum, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19 58 to 20 Dec. 19 59 , that I last saw the deceased alive on 19 Dec. 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris Rainess		ADDRESS (Street, city or town, state) 1105 OLD EASTERN AVE.	
PHYSICIAN'S NAME (Type) MORRIS RAINESS, MD.		DATE SIGNED 12-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 23, 1959	
22c. NAME OF CEMETERY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann		ADDRESS 3218 HUDSON ST.	
24a. REC'D BY REGISTRAR DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

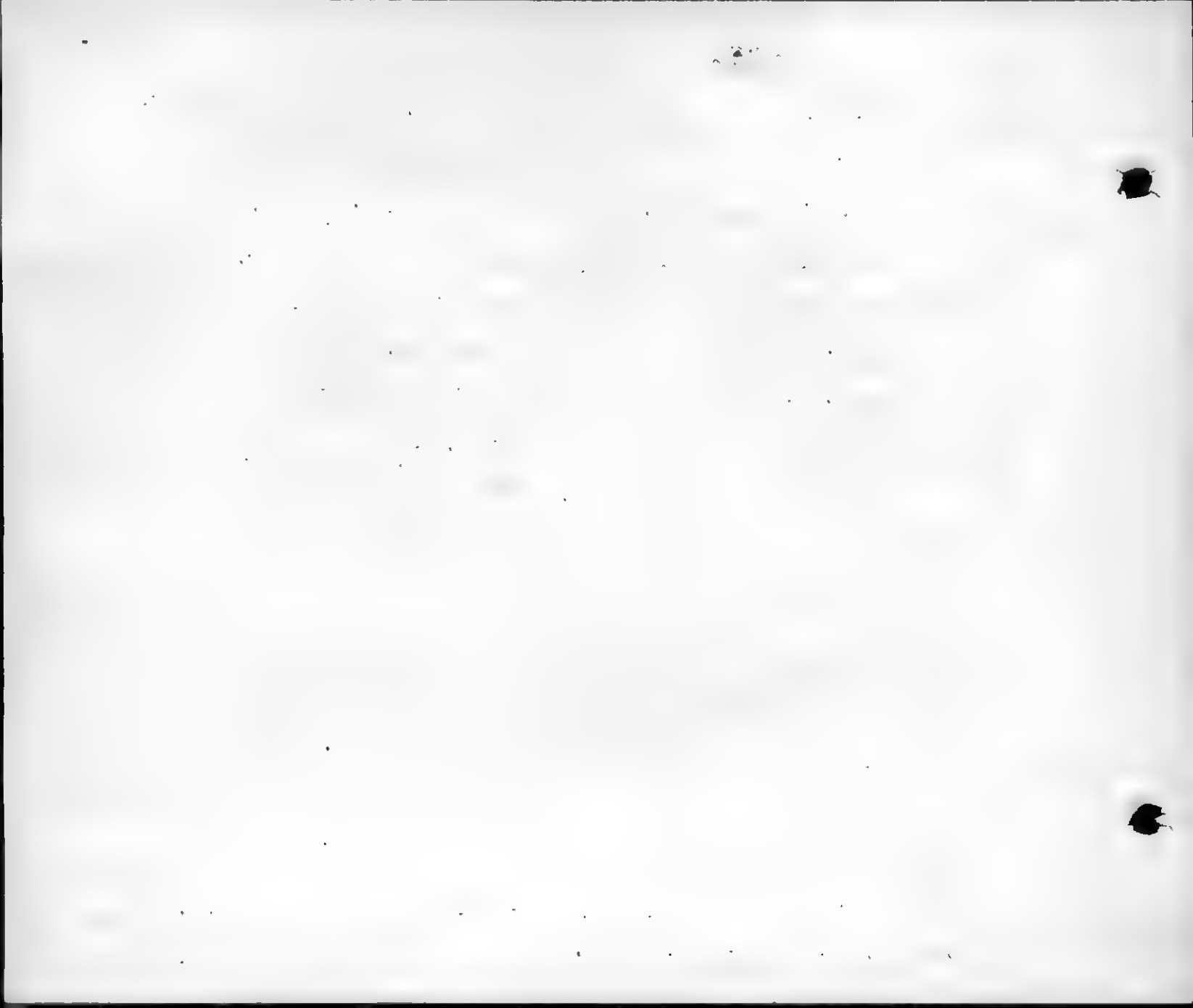
Reg. Dist. No.

13374

13398

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7901 Oakleigh Rd.</i>		e. STREET ADDRESS <i>7901 Oakleigh Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Hilda</i> Middle <i>Amelia</i> Last <i>Giannaccini</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 5, 1903</i>
9. AGE (In years last birthday) <i>56</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>2</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Walter W. Lutz</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Captain</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>John W. Kruse</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Thrombosis</i> DUE TO (b) <i>Arteriosclerotic Myocardiosclerosis</i> DUE TO (c) <i>2 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from <i>9/6</i> , 19 <i>59</i> , to <i>12/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/24</i> , 19 <i>59</i> , and that death occurred at <i>1:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm Conway</i>		DATE SIGNED <i>8358 Loch Raven Blvd. Towson 4, Md.</i>	
PHYSICIAN'S NAME (Type) <i>W. M. Conway M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>1-2-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>DEC 31 59</i>	
24b. REGISTRAR'S SIGNATURE <i>John D. Ruck</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13399

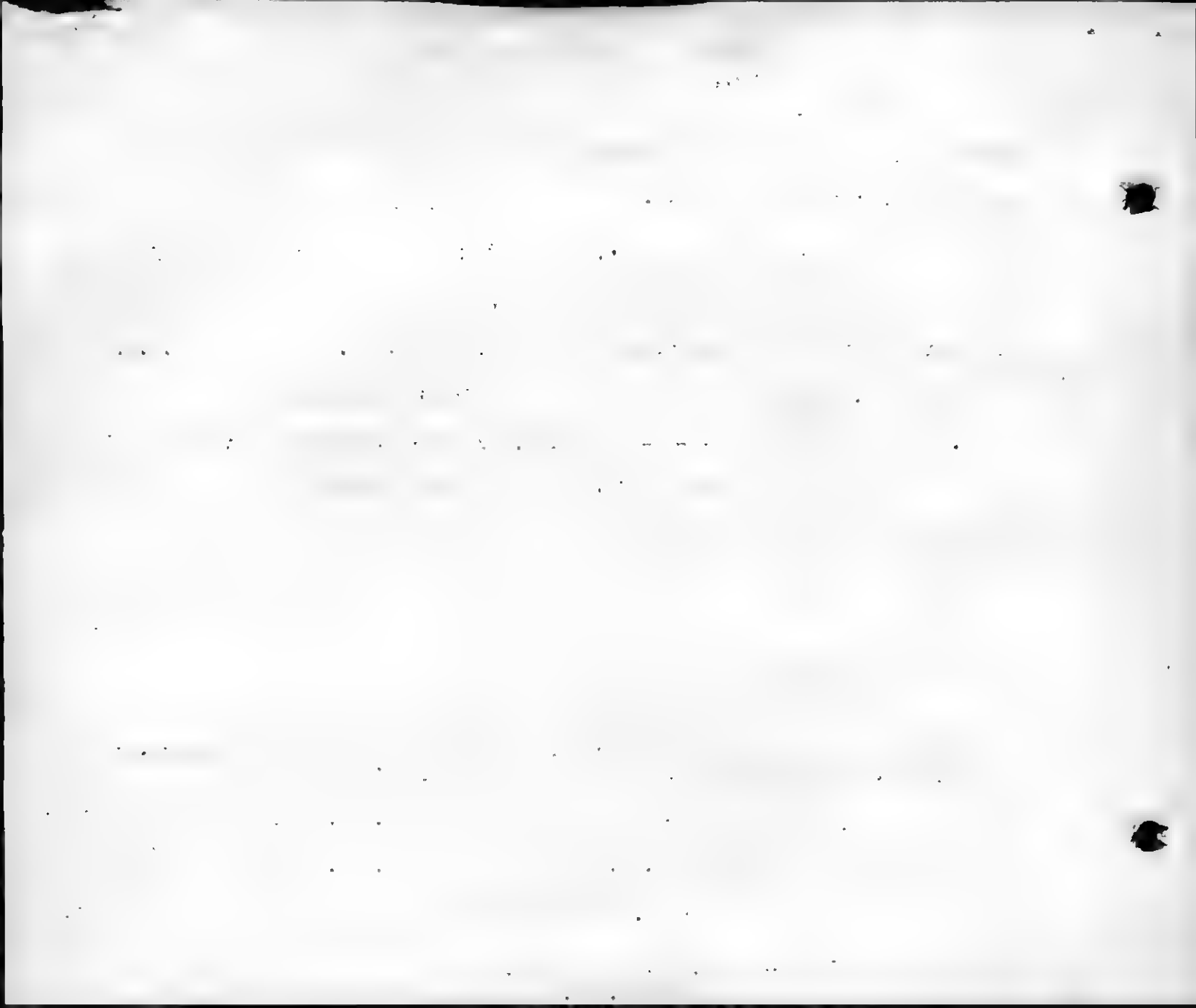
CERTIFICATE OF DEATH

13375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 302 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last GIBSON		4. DATE OF DEATH Month December Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1919
9. AGE (In years last birthday) 40		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor Operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Gibson		14. MOTHER'S MAIDEN NAME Martha Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 220-07-3334	
INFORMANT Address Clin. Records VAH Balto 18 Md Ft Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO CHRONIC GLOMERULONEPHRITIS X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 2, 1959 to December 30, 1959 , and that death occurred at 11:10 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. MD. FT HOWARD DIV 12/31/59			
ACTUAL SIGNATURE Martin W. Gottleib M.D.		PHYSICIAN'S NAME (Type) MARTIN W. GOTTLEIB, M. D. VAH, BALTO. MD. FT HOWARD DIV 12/31/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/60	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Nutter Funeral Home, 3810 Bonner Rd. Balto. Md.		24a. REC'D BY REGISTRAR JAN 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Page 4
The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b 13yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Trenton Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rachel Virginia (Jennie) Gill		4. DATE OF DEATH Dec. 17, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1881
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Wesley Price		14. MOTHER'S MAIDEN NAME Amanda Derr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mitchell Hale, Upperco, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1950 to Dec 17 1959 , that I last saw the deceased alive on Dec 16 1959 , and that death occurred at 10:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Foad		ADDRESS (Street, city or town, state) MANCHESTER, MD	
PHYSICIAN'S NAME (Type) W. H. Foad M.D.		DATE SIGNED 12-17-59	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Paul		22d. LOCATION (City, town, or county) (State) Arcadia, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hous			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13377

13401

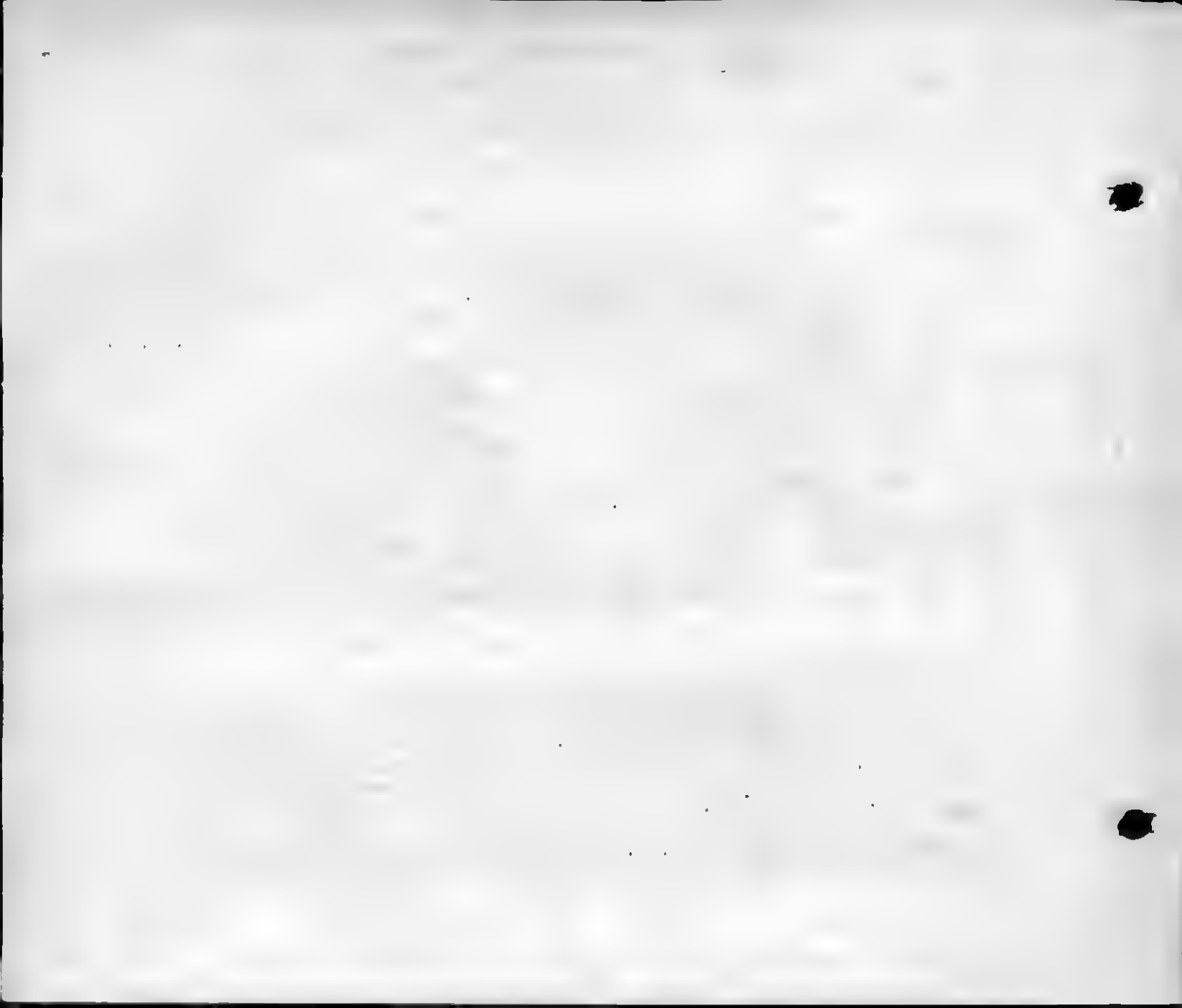
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5mth3dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Star Route #3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Milford Middle Hancock Last Hancock				4. DATE OF DEATH Month December Day 10 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1877	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma of pharynx 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept. 28, 19 59 to December 10, 19 59 , that I last saw the deceased alive on Dec. 10, 19 59 , and that death occurred at 10:10 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-15-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville, 28, Maryland			
22a. BURIAL, CREMATION, CREMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/7/59		Catholic		4300 Old Frederick	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Zaher				ADDRESS 1318 Light		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



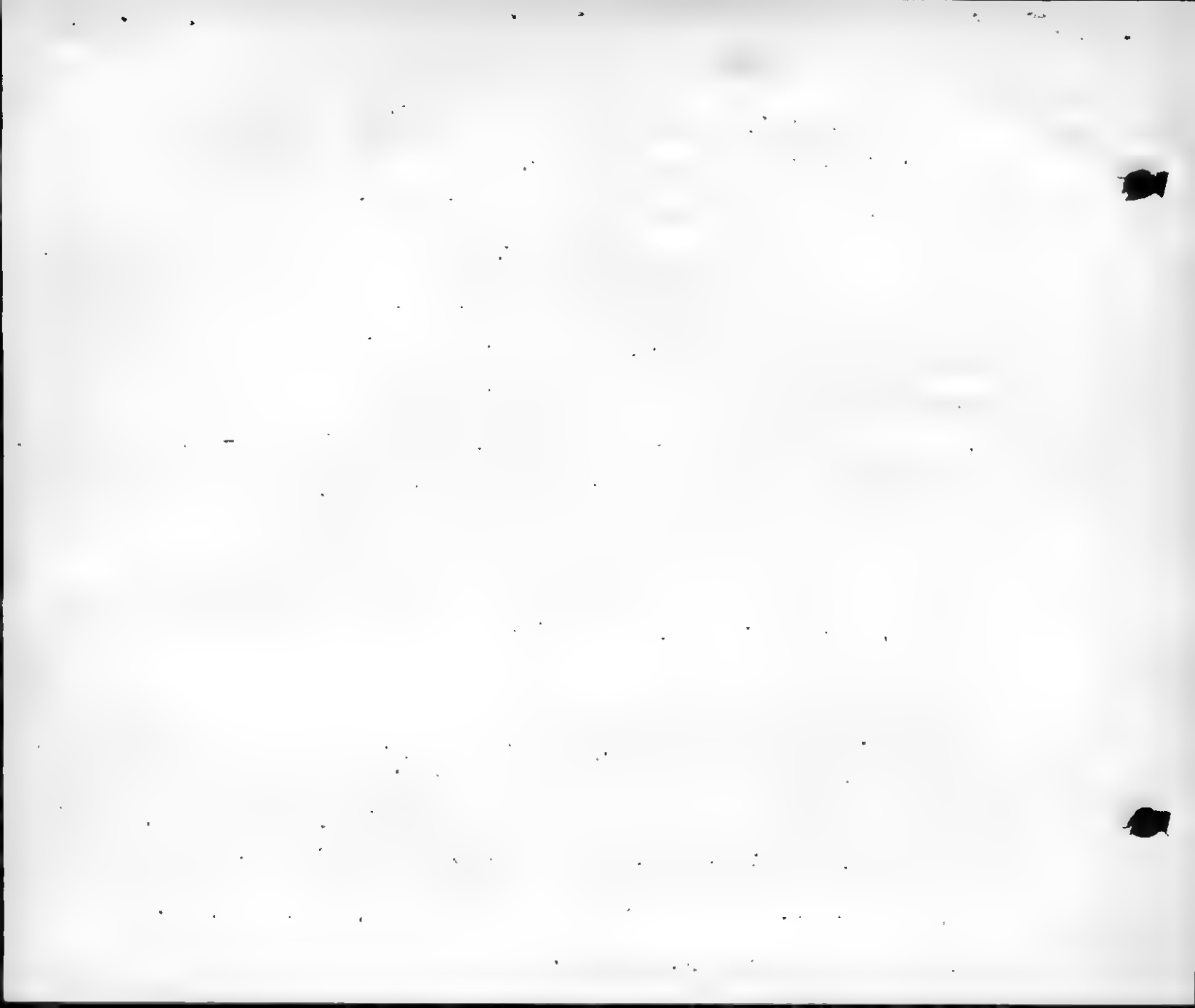
Reg. Dist. No.

13402

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 13403 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 440 White Thorn Way		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River d. STREET ADDRESS 440 White Thorn Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PEARL MAE HEDDERMAN		4. DATE OF DEATH Month Day Year December 28, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1893 66 yrs.
9. AGE (In years, months, days) Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Kraft		14. MOTHER'S MAIDEN NAME Sara Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mr. Edward Brown-440 White Thorn Way -20	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Cerebral Disease DUE TO (b) Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE MB Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M B DAVIS M.D.		DATE SIGNED 12/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Balto., Md.		24a. REC'D BY REGISTRAR JAN 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13404

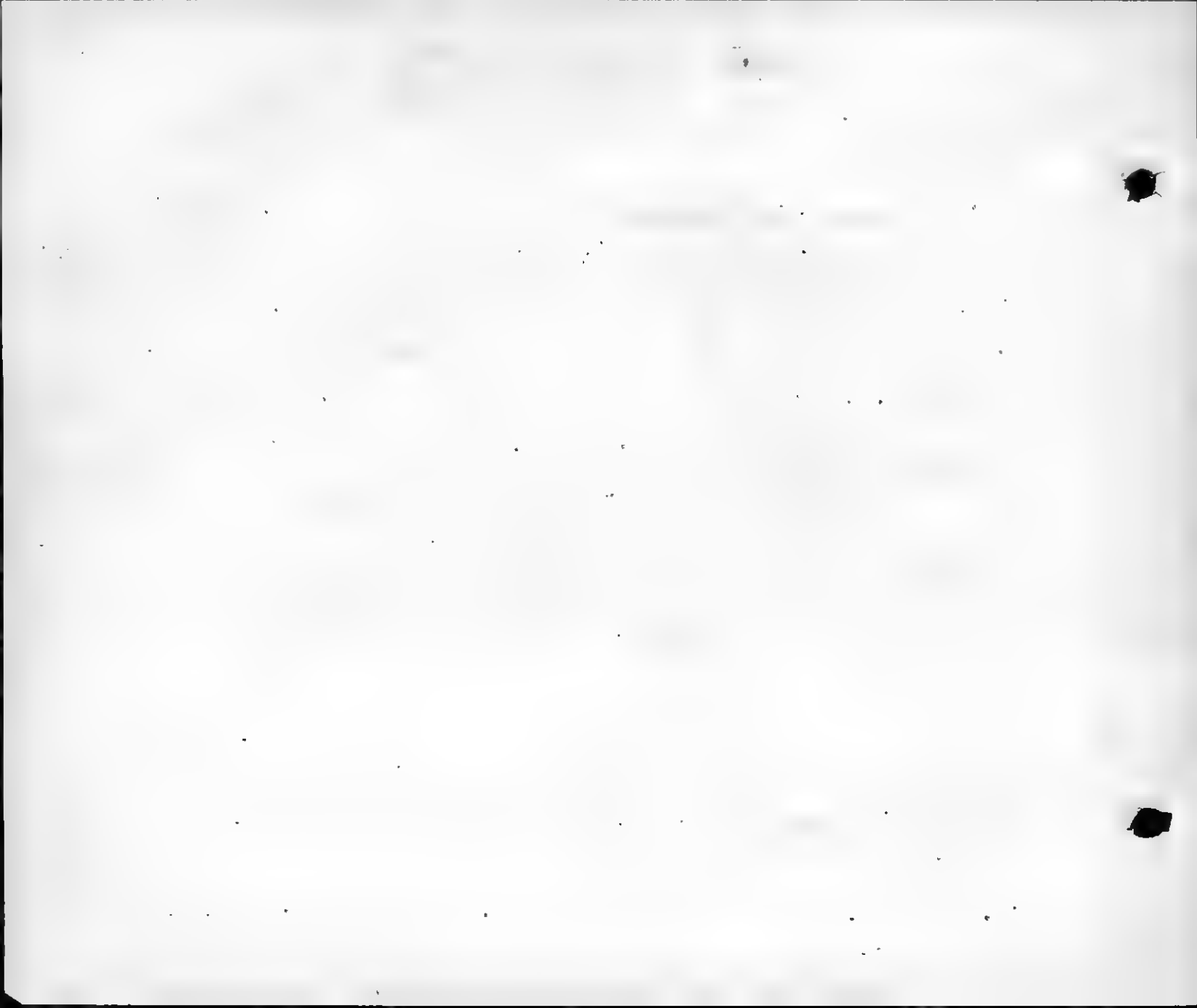
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Linda's home</i>		d. STREET ADDRESS <i>10 Beaumont Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>LAURA C. HEINMUELLER</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>2/21/77</i>	9. AGE (In years last birthday) <i>82</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Edw. Seidel</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Mosberger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>Miss Hilda Heinmuelle</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic C.V. Disease</i> DUE TO (b) <i>Angioma of Left @ Tempora</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture of Left Hip-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>1 wk</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-1</i> , 19 <i>56</i> , to <i>12-4</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12-4-59</i> , 19 <i>59</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. Howard</i> M.D.		ADDRESS (Street, city or town, state) <i>Catonsville</i> DATE SIGNED <i>12-6</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/7/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Webb + Son</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 8 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

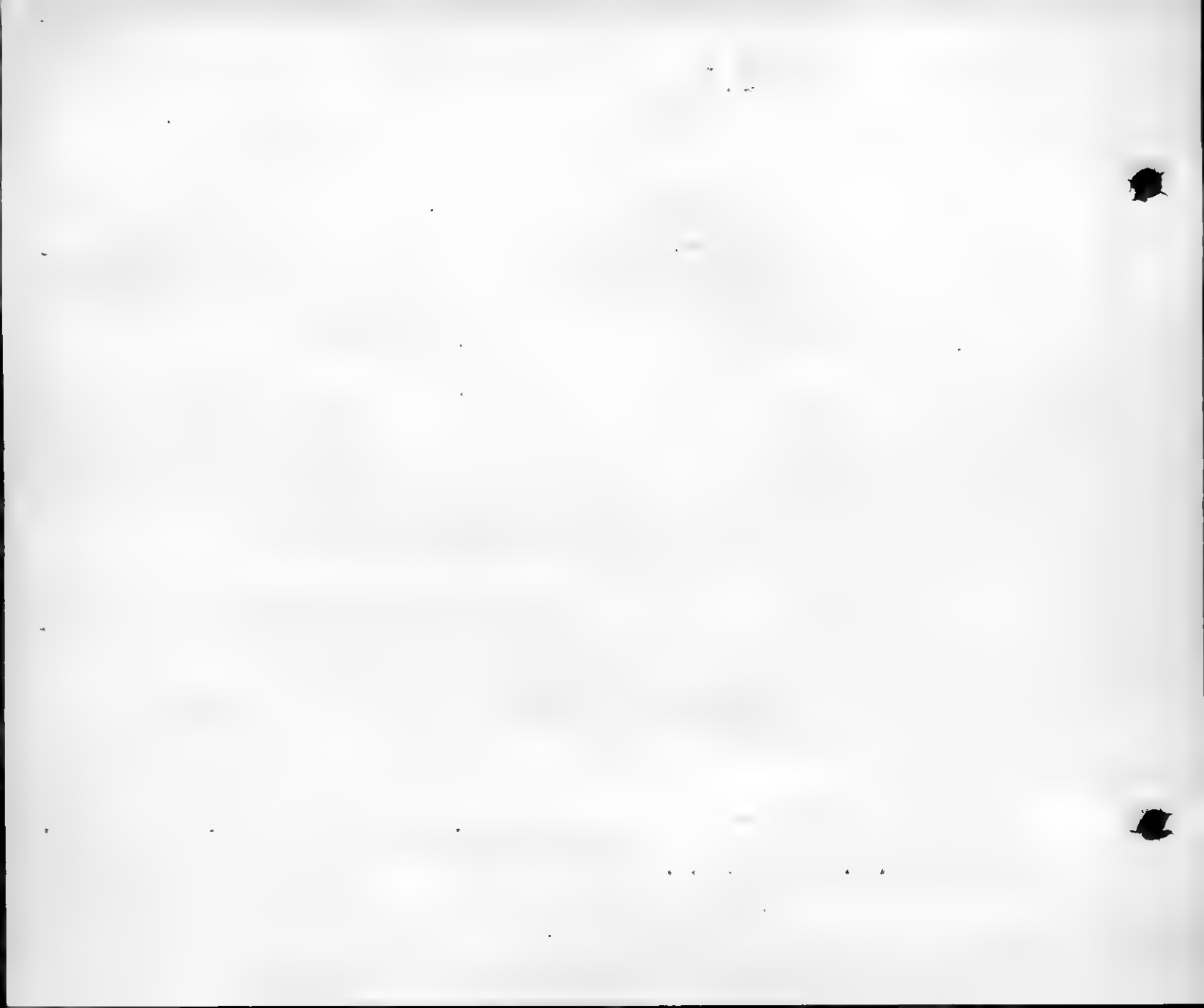
13381

13405

1. PLACE OF DEATH a. COUNTY <u>17Aigburth Road Towson #4</u> <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson #4</u>		c. LENGTH OF STAY IN lb <u>33 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>17Aigburth Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Johnston</u> Last <u>Herring</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27-1888</u>
9. AGE (In years lost birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Lee Johnston</u>		14. MOTHER'S MAIDEN NAME <u>Mary Marriott Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Robert Q. Herring (Husband)</u>		Address <u>Towson #4</u> <u>17Aigburth Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>491X</u> DUE TO (b) <u>BRUNCHED-PNEUMONIA, BILATERAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/18</u> , 19 <u>59</u> to <u>12/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>59</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. C. Szwinski</u>		ADDRESS (Street, city or town, state) <u>17 W. Pennsylvania Avenue, Towson 4, Md.</u>	
PHYSICIAN'S NAME (Type) <u>T. C. Szwinski, M.D.</u>		DATE SIGNED <u>12/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>DEC 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY MEM'L GARDENS</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. VENKINS SONS</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
ADDRESS <u>4905 YORK ROAD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Forge Haven Drive		d. STREET ADDRESS 14 Forge Haven Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle ISSABELLE Last HERTZOG		4. DATE OF DEATH Month December Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1910
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Penna	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. McKean		14. MOTHER'S MAIDEN NAME Iva Beachel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Robert L. Hertzog	
17. INFORMANT Robert L. Hertzog		Address 14 Forge Haven Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 131X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) U DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 29, 1959 to Dec 29, 1959 , that I last saw the deceased alive on 19 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert L. Hertzog M.D.			
PHYSICIAN'S NAME (Type) Robert L. Hertzog			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/59	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		24a. REC'D BY REGISTRAR DATE DEC 31 '59	
ADDRESS 4210 Belair Road.		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13407

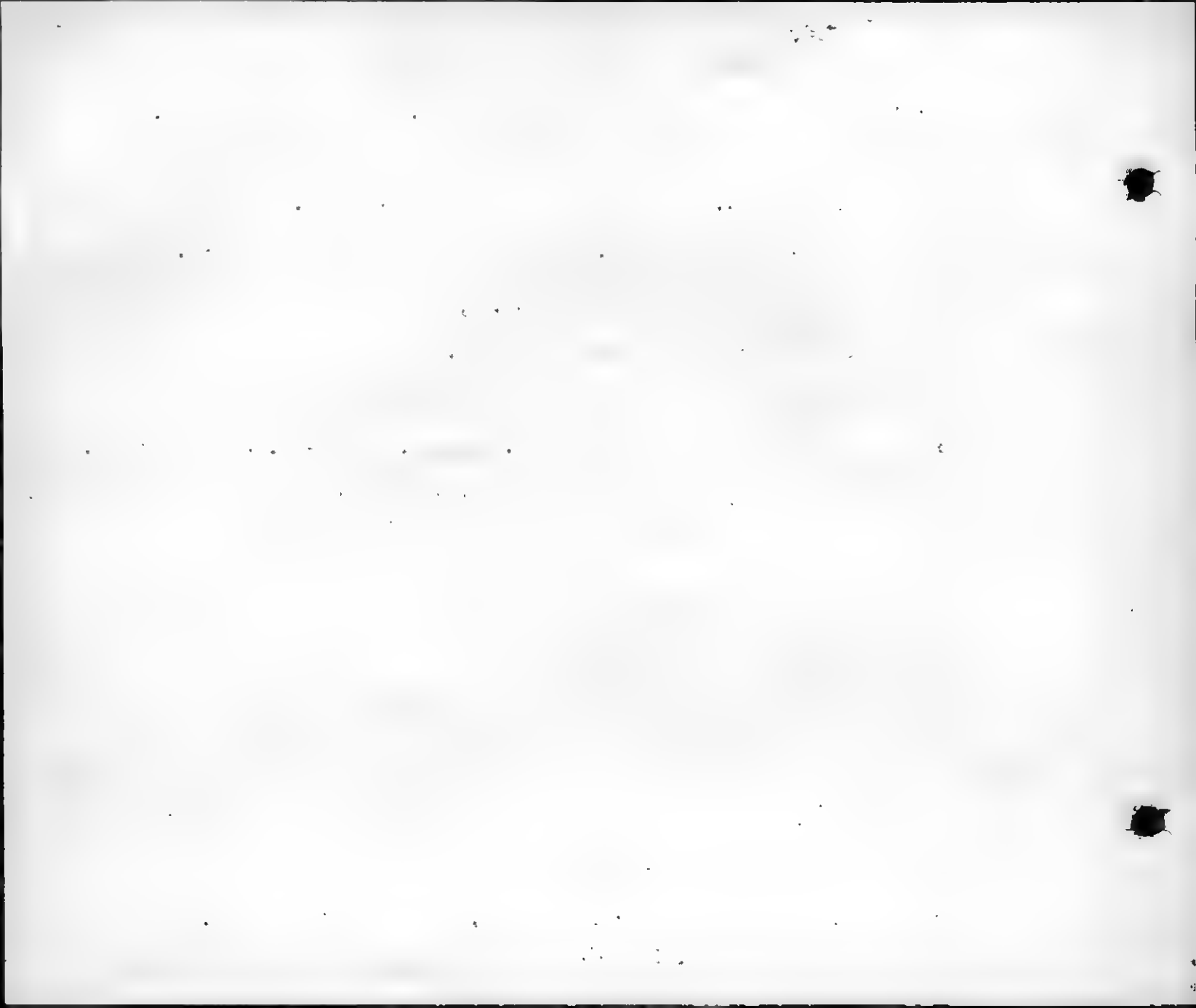
CERTIFICATE OF DEATH

Reg. Dist. No.

13383

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6405 Pinehurst Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last HIMES		4. DATE OF DEATH Month Dec. Day 10 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min 72	11. IF UNDER 24 HRS Months 72 Days 72 Hours 72 Min 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd (Office Manager)		10b. KIND OF BUSINESS OR INDUSTRY Contractors	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Himes		14. MOTHER'S MAIDEN NAME Emma Gardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Informant Address Mrs. Helen F. Himes - 6405 Pinehurst Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aneurysm 401X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/10 , 19 59 , to 12/10 , 19 59 , that I last saw the deceased alive on 12/10 , 19 59 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Franklin E. Leslie		ADDRESS (Street, city or town, state) 2429 N. Charles Baltimore Md	
PHYSICIAN'S NAME (Type) Franklin E. Leslie		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORY Louder Park Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Balto, Md.		24a. REC'D BY REGISTRAR DATE DEC 10 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13408

CERTIFICATE OF DEATH

15384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 N. Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last HOLLAND		4. DATE OF DEATH Month Dec. Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1885
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Wolf		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Gordon M. Holland - 103 N. Rolling Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRA VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1957 to Dec 20, 1959 , that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1011 Frederick Road Cat 28, Md. DATE TYPED ACTUAL SIGNATURE James E. Rowe M.D. PHYSICIAN'S NAME (Type) James E. Rowe, M.D. Ri. 7 4252			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/59	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Pickner & Sons - Battle 17		24a. REC'D BY REGISTRAR DATE DEC 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McComas Rd.</u>		e. STREET ADDRESS <u>McComas Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Chloe Belle Hoshall</u>		4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1872</u>
9. AGE (In years, months, days, hours, minutes) <u>87</u> yrs		10. IF UNDER 1 YEAR (If under 24 hrs.) Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hezekiah Best Miller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Upton Hoshall, White Hall, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardiovascular disease</u> DUE TO <u>Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic</u> (c) <u>Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1950</u> to <u>Dec 21, 1959</u> that I last saw the deceased alive on <u>Dec 21, 1959</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u>		DATE SIGNED <u>12/21/59</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		ADDRESS (Street, city or town, state) <u>Parkton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Hartman, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

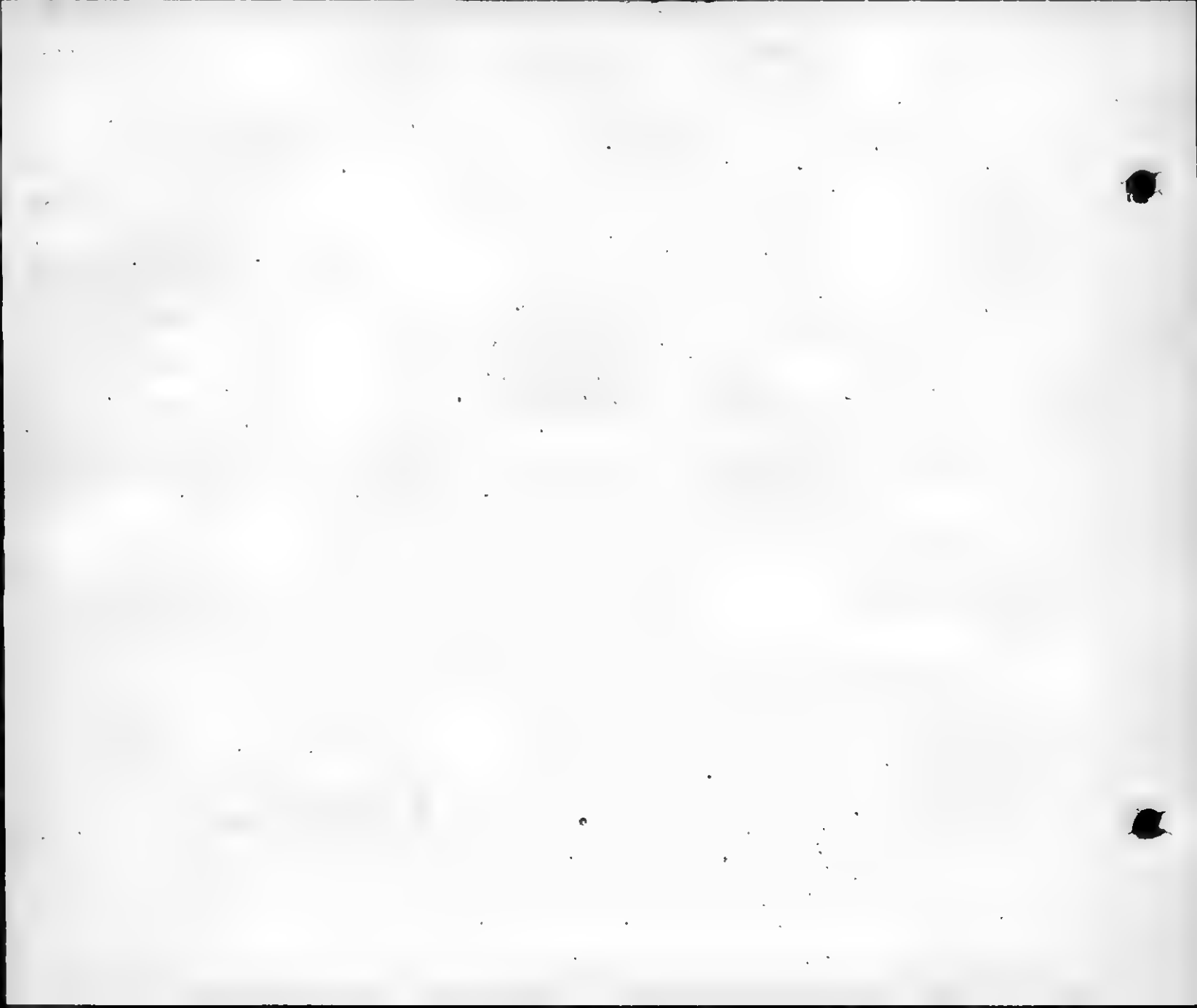
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

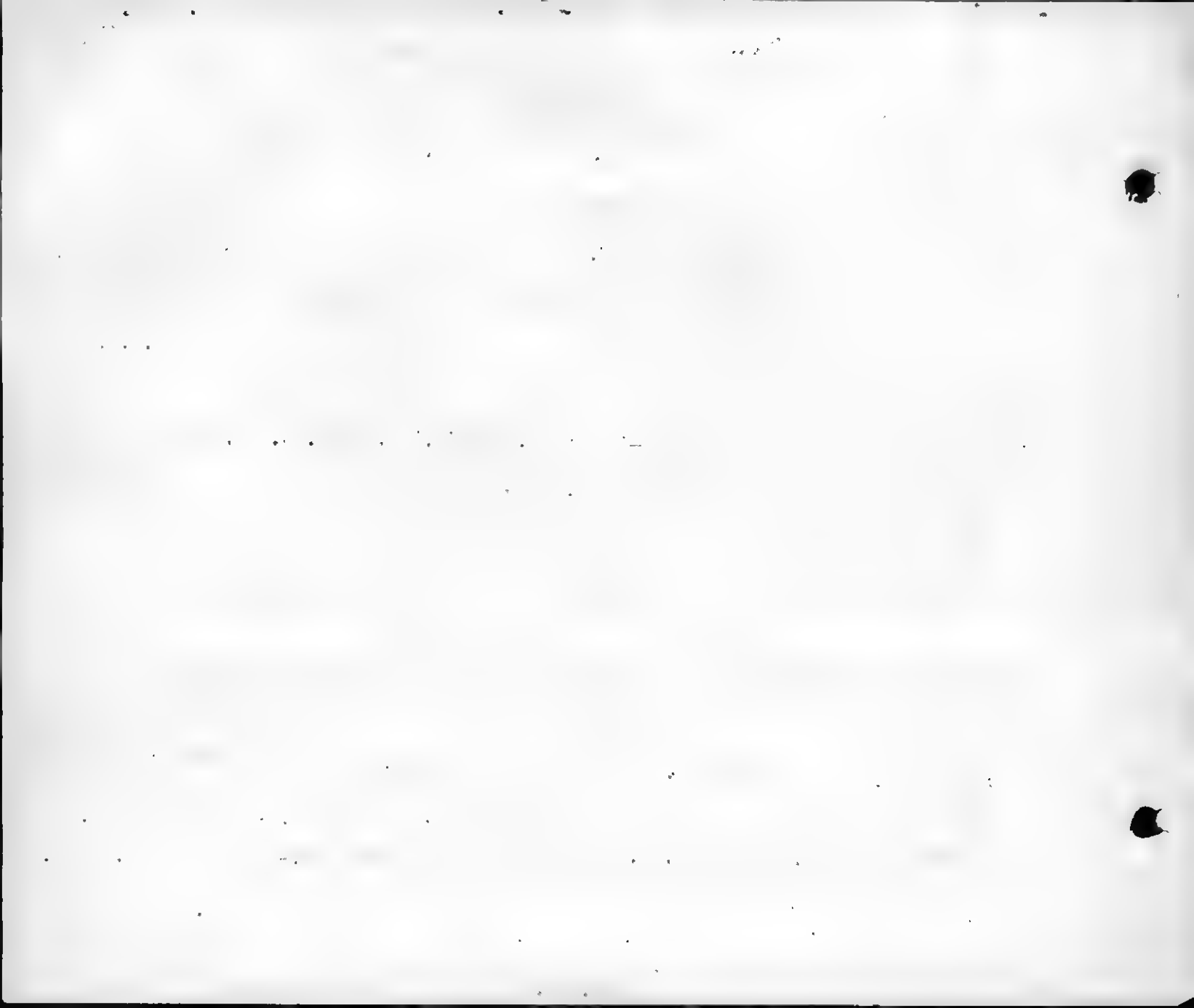
13386

13410

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY 7	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 201 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle T. Last HOWARD		4. DATE OF DEATH Month December Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1892
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Howard		14. MOTHER'S MAIDEN NAME Rachel Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-7039	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INFORMANT Address Clin. Records. VAH, Balto. Md. Ft. Howard Division	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 14, 1959 to December 1, 1959 , and that death occurred at 3:20 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel A. Nieves		ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTIMORE, MD. - FT HOWARD DIV. 12/1/59	
PHYSICIAN'S NAME (Type) DANIEL A. NIEVES, M. D.		VAH, BALTIMORE, MD. - FT HOWARD DIV. 12/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/4/59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Glen B. Knie		24b. REGISTRAR'S SIGNATURE Arthur S. Knie	
ADDRESS Glen B. Knie, M.D. Hopping & Kirkley Funeral Home, 421 Crain Hwy		DATE DEC 7 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13387
Item 18 Film 255 - 13387										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARTFORD Rd.</u>					1. d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arden</u> Last <u>Howard</u>					4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1895</u>		9. AGE (In years last birthday) <u>64</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Baltimore</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William H. Howard</u>					14. MOTHER'S MAIDEN NAME <u>India Howard</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-64-5768</u>		17. INFORMANT <u>Sadie Howard</u> Address <u>none</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>W. B. King</u> EXAMINER'S NAME (Type) <u>W. Bradley King Jr MD</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cem</u>			22d. LOCATION (City, town, or county) (State) <u>Long Green Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hermond J. Nick 5305 HARTFORD Rd.</u>					24a. REC'D BY REGISTRAR DATE <u>DEC 29 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13388

13412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY CATONSVILLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 10 YRS		CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5926 Cecil Ave.		d. STREET ADDRESS 5926 Cecil Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle Isensee Last Isensee		4. DATE OF DEATH Month Dec. Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 8 Days 7 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U. S. C.	
13. FATHER'S NAME MARTIN TUNNEMANN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. WILLIAM F. ISENSEE		Address BALTO. 7 MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial 4222 DUE TO Cardiac Distention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10 , 19 59 , to Dec 7 , 19 59 , that I last saw the deceased alive on Dec 7 , 19 59 , and that death occurred at 4:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Katzenberger		M.D. 4/1/59 Isensee	
PHYSICIAN'S NAME (Type) JAMES W. KATZENBERGER		DATE SIGNED 12/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12/16/1959	Landon Park Cem.	Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. Truman Schwab		ADDRESS 3512 Frederick Ave. 29.	
24a. REC'D BY REGISTRAR DEC 18 1959		24b. REGISTRAR'S SIGNATURE Carlton E. Hines	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

13413

Items 7, 9 fill G253 12-23-59 et

CERTIFICATE OF DEATH

13389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood ST. Tr School</u>		d. STREET ADDRESS <u>Box 72 Darlington, Md</u>	
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>Darnell</u> Last <u>JAYNES</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-57</u>
9. AGE (In years last birthday) <u>4</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>22</u>	
11. IF UNDER 24 HRS Hours <u></u> Min <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Leon Jaynes</u>		14. MOTHER'S MAIDEN NAME <u>Beulah May Citting</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u> INFORMANT Address <u>Rosewood Records Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause (b) <u>Inanition</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus with meningomyelocele (Arnold-Chiari Syndrome)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/13/59</u> to <u>12/14/59</u> that I last saw the deceased alive on <u>12/13/59</u> and that death occurred at <u>12/14/59</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>12/14/59</u> ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u> <u>Rosewood Tr. School, Owings Mills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clark Chapel Am</u>		22d. LOCATION (City, town, or county) (State) <u>Hanford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bailey</u> ADDRESS <u>Darlington, Md</u>		24. REC'D BY REGISTRAR <u>DEC 17 '59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

Harford

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13414

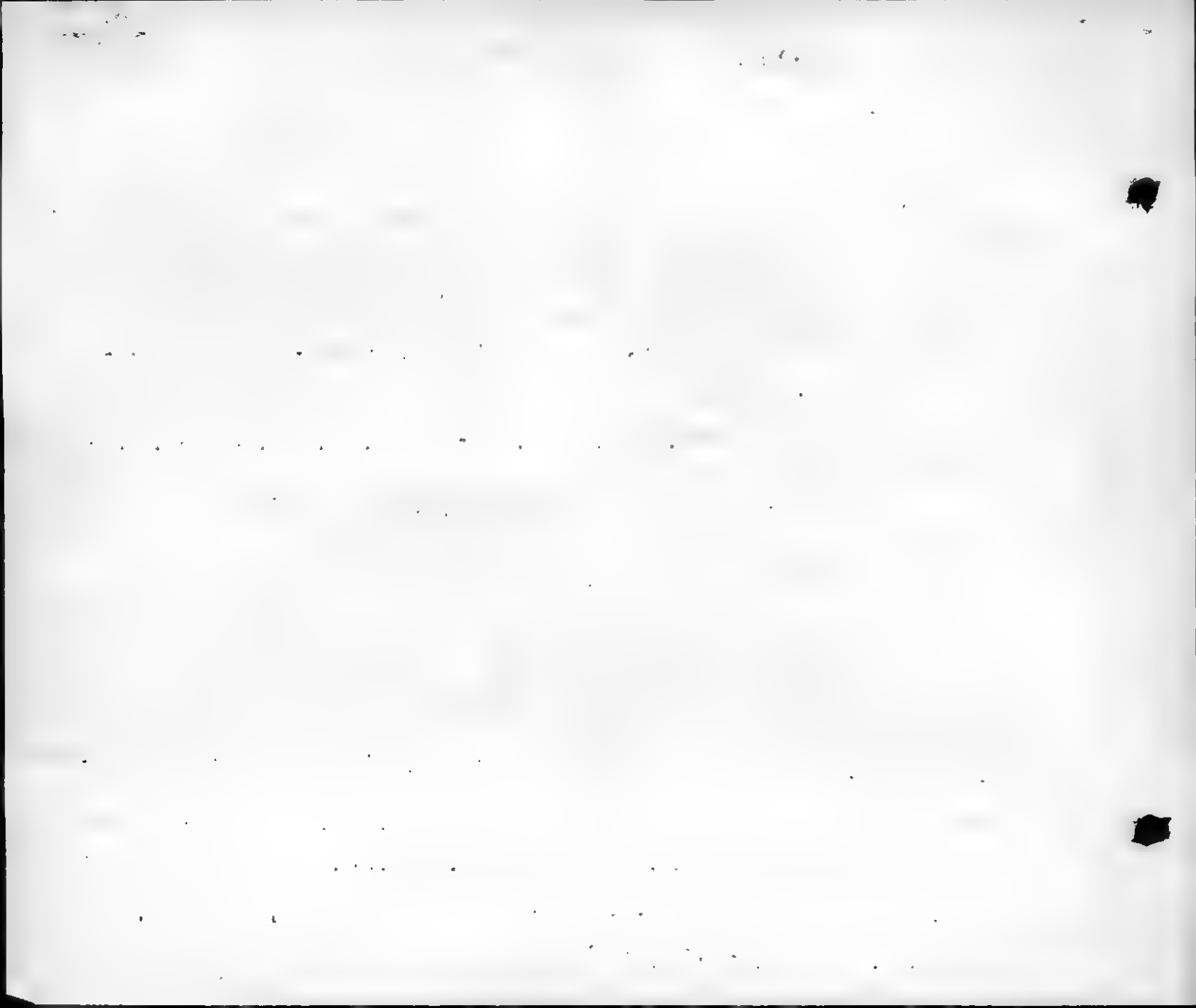
CERTIFICATE OF DEATH

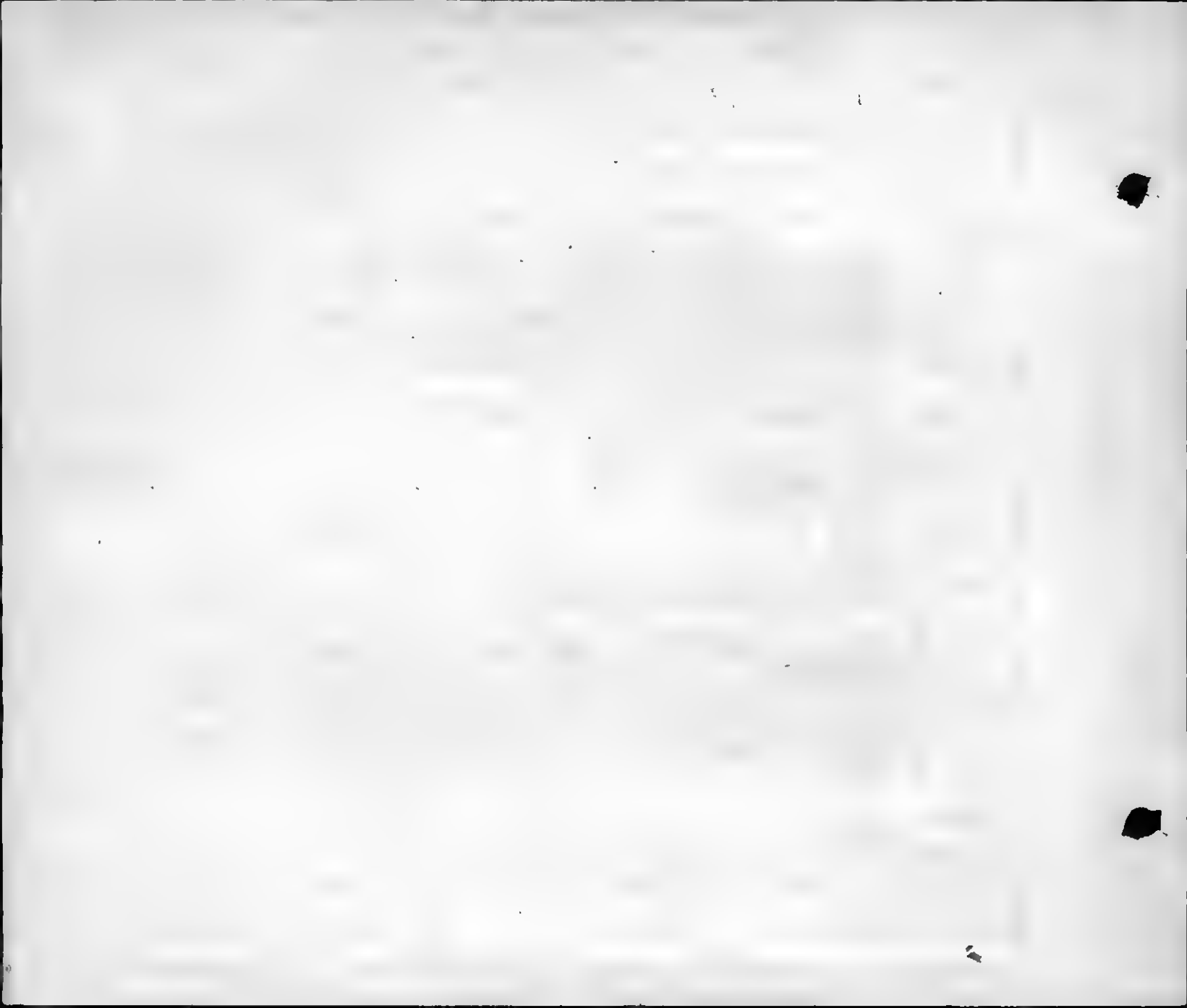
Reg. Dist. No.

13390

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2 V 01 - 4			
f. STREET ADDRESS 1604 Harlem Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ISADORE Middle (NMI) Last JENNINGS				4. DATE OF DEATH Month December Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/22/89	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Brooklyn, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William H. Jennings				14. MOTHER'S MAIDEN NAME Dorinda Burley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. INFORMANT Address Clin. Records, Vets. Adm. Hosp. Balto, Md. Ft. Howard Div			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 161X IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA OF LARYNX WITH METASTASIS TO THE CERVICAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CACHEXIA (c) EDEMA OF LUNGS INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 2 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 4, 1959 to December 8, 1959 and that death occurred at 10:42A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO., MD. FORT HOWARD DIVISION DATE SIGNED John W. Crawford							
ACTUAL SIGNATURE John W. Crawford M.D.				PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO., MD. FORT HOWARD DIVISION			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-11-1959			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, Baltimore 17, Maryland				24a. REC'D BY REGISTRAR DEC 14 '59 24b. REGISTRAR'S SIGNATURE Orlino S. Thomas			

Page 4
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13416

CERTIFICATE OF DEATH

Reg. Dist. No. **13392**

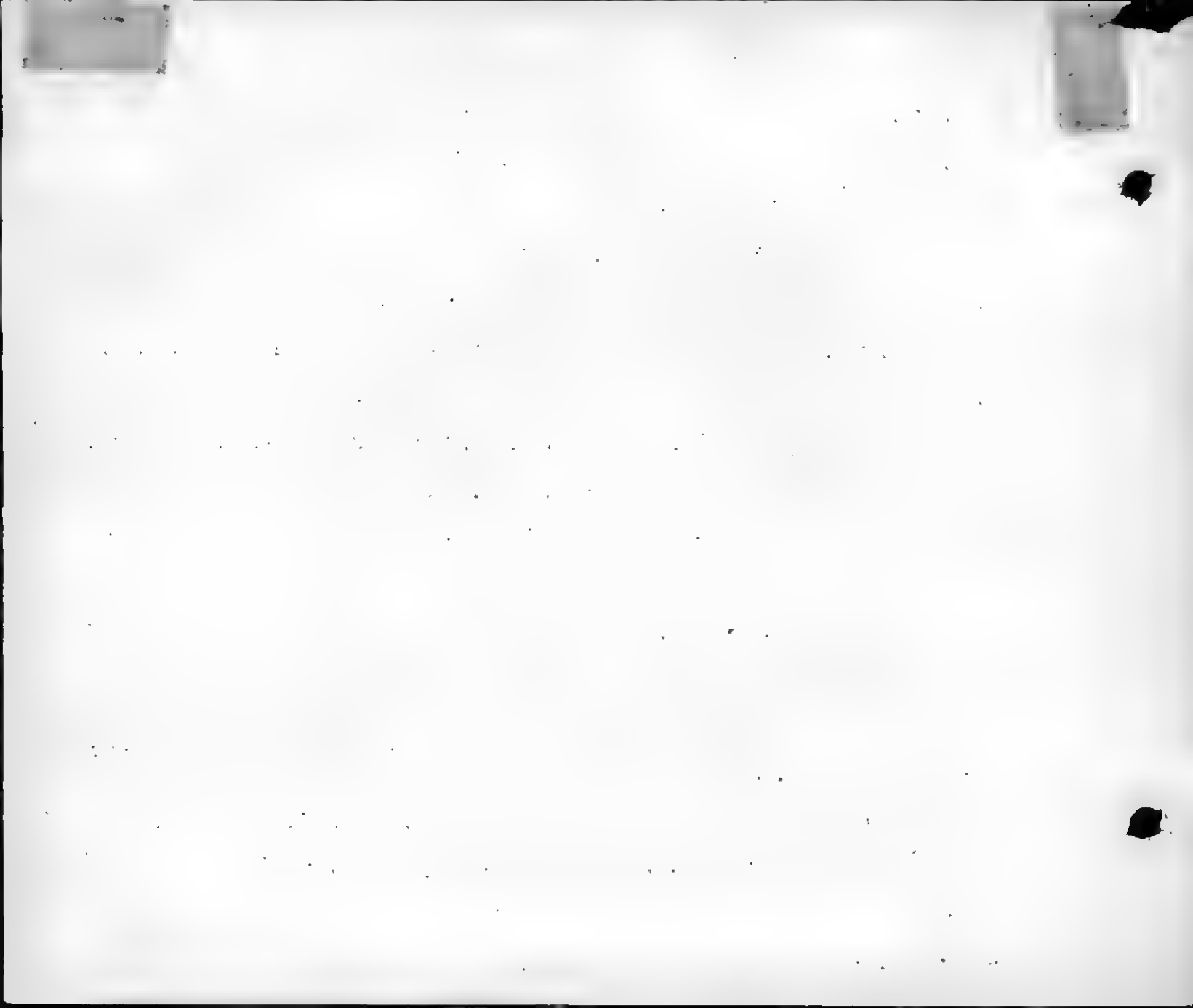
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERT Middle W. Last JOHNSON		4. DATE OF DEATH Month December Day 16 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1888
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter - Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Battle Creek, Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Johnson		14. MOTHER'S MAIDEN NAME Jeanette Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 158-09-4632	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard Division		Address: Baltimore 18, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 471X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abscess, post thoracic wall, right		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 8, 19 59, to December 16, 19 59 , and that death occurred at 6:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. VAH, BALTO. 18, MD., FT. HOWARD DIVISION DATE SIGNED 12/18/59			
ACTUAL SIGNATURE John W. Crawford		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/18/59	
22c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		22d. LOCATION (City, town, or county) (State) Omaha, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808, 10 Monroe St. Balto. Md.		24a. REC'D BY REGISTRAR DEC 21 59	
ADDRESS 2416 N. 22nd St., Omaha, Nebraska		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

SHIPPED TO: MYERS BROS. FUNERAL HOME, 2416 N. 22nd St., Omaha, Nebraska



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13417

CERTIFICATE OF DEATH

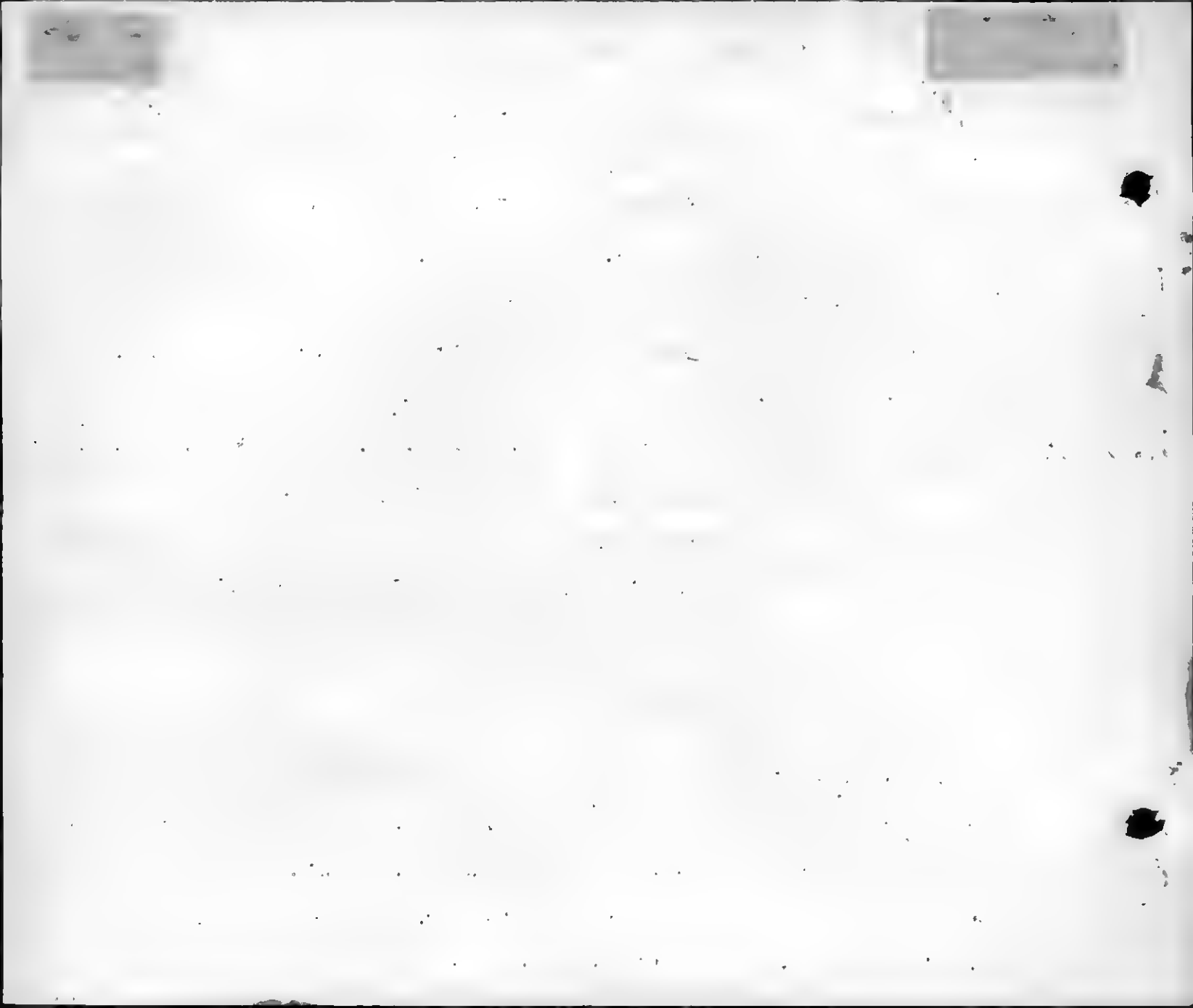
Reg. Dist. No.

13393

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 61 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARROLL Middle M. Last JONES, JR.				4. DATE OF DEATH Month December Day 3 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1920	
9. AGE (In years lost birthday) yrs. 39		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman				10b. KIND OF BUSINESS OR INDUSTRY Refrgeration		11. BIRTHPLACE (State or foreign country) Goldsboro, Maryland	
13. FATHER'S NAME Carroll M. Jones, Sr.				14. MOTHER'S MAIDEN NAME Delia Meredith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW II				16. SOCIAL SECURITY NO 717-10-6403			
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard				Address Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA, RIGHT TEMPORAL AND OCCIPITAL REGIONS 193.0 DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) (b) EDEMA OF LUNGS DISEASE (c) CHRONIC PASSIVE CONGESTION, LUNGS, LIVER & SPLEEN							INTERVAL BETWEEN ONSET AND DEATH 1 YEAR FEW HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from October 3, 1959 to December 3, 1959 and that death occurred at 8:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford				ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FORT HOWARD DATE SIGNED 12/4/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.				VAH, BALTO. 18, MD. FT. HOWARD DIVISION 12/4/59			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				ADDRESS 6909 Harford R. Balto. 14, Md.		24a. REC'D BY REGISTRAR DEC 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13418

CERTIFICATE OF DEATH

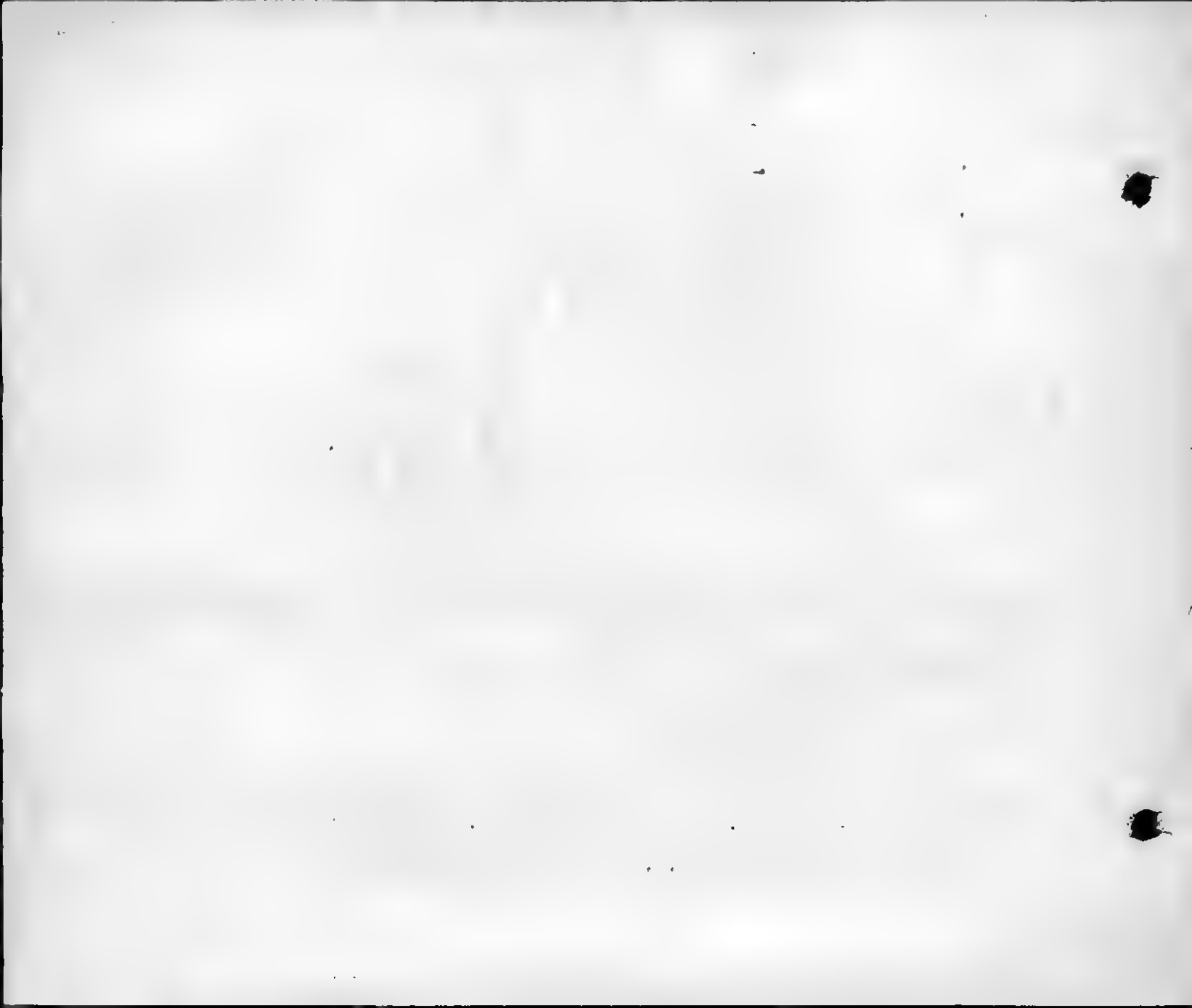
Reg. Dist. No.

13394
32

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3429 RAVENWOOD AVE BALTO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 3429 RAVENWOOD AVE			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE EDWARD JONES				4. DATE OF DEATH Month Day Year DEC. 21 1959			
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 3, 1891	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE T. JONES				14. MOTHER'S MAIDEN NAME MARY WINDSOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-18-1512A		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS						INTERVAL BETWEEN ONSET AND DEATH 9 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-18 19 59 to 12-21 19 59 , that I last saw the deceased alive on 12-21 19 59 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William Newcomer, M.D.				M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-24-1959		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		22d. LOCATION (City, town, or county) (State) NORTH AVE BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Walter Corbin				ADDRESS 5444 Belair Rd.		24a. REC'D BY REGISTRAR DEC 23 59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knap			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13395

13331

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7019 Dunbar Road		d. STREET ADDRESS 7019 Dunbar Road	
3. NAME OF DECEASED (Type or print) First IDA Middle S. Last JONES		4. DATE OF DEATH Month December Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Sandridge		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Mrs. Mary J. Bowen 7019 Dunbar Road, --22,	
17. INFORMANT Mrs. Mary J. Bowen 7019 Dunbar Road, --22,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20 19 59 , to December 1 , 19 59 , that I last saw the deceased alive on December 1 , 19 59 , and that death occurred at 5 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2900 Dunbar Road, 12/1/59			
ACTUAL SIGNATURE B.W. Sollod		M.D. 2900 Dunbar Road,	
PHYSICIAN'S NAME (Type) B.W. Sollod, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 3, 1959	22c. NAME OF CEMETERY OR CREMATORY Mountain Plain Cemetery	22d. LOCATION (City, town, or county) (State) Mechum River, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13419

CERTIFICATE OF DEATH

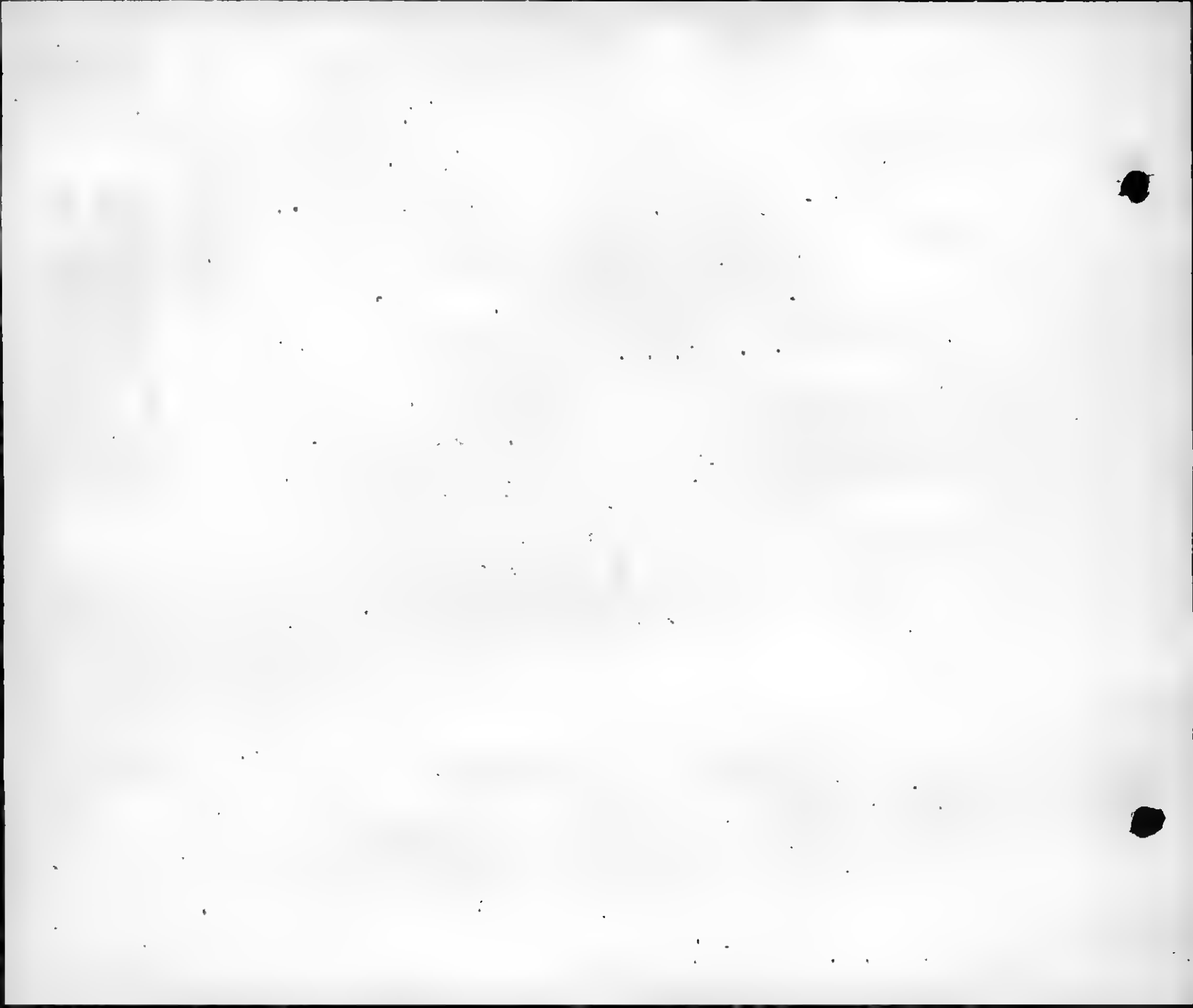
Reg. Dist. No. 13396

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9625 Mason Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Leroy</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <u>Freight Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leischer Jones</u>		14. MOTHER'S MAIDEN NAME <u>Alice A. Caltrider</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. Address <u>Mrs. Bertha Jones, 9625 Mason Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 241x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Chronic Asthma</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema & Chronic Asthma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12/29</u> , 19 <u>50</u> , to <u>Dec 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>50</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1123 St Paul St Baltimore 2 Md</u> DATE SIGNED ACTUAL SIGNATURE <u>H. D. Franklin</u> M.D. PHYSICIAN'S NAME (Type) <u>H. D. Franklin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/2/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraw</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13420

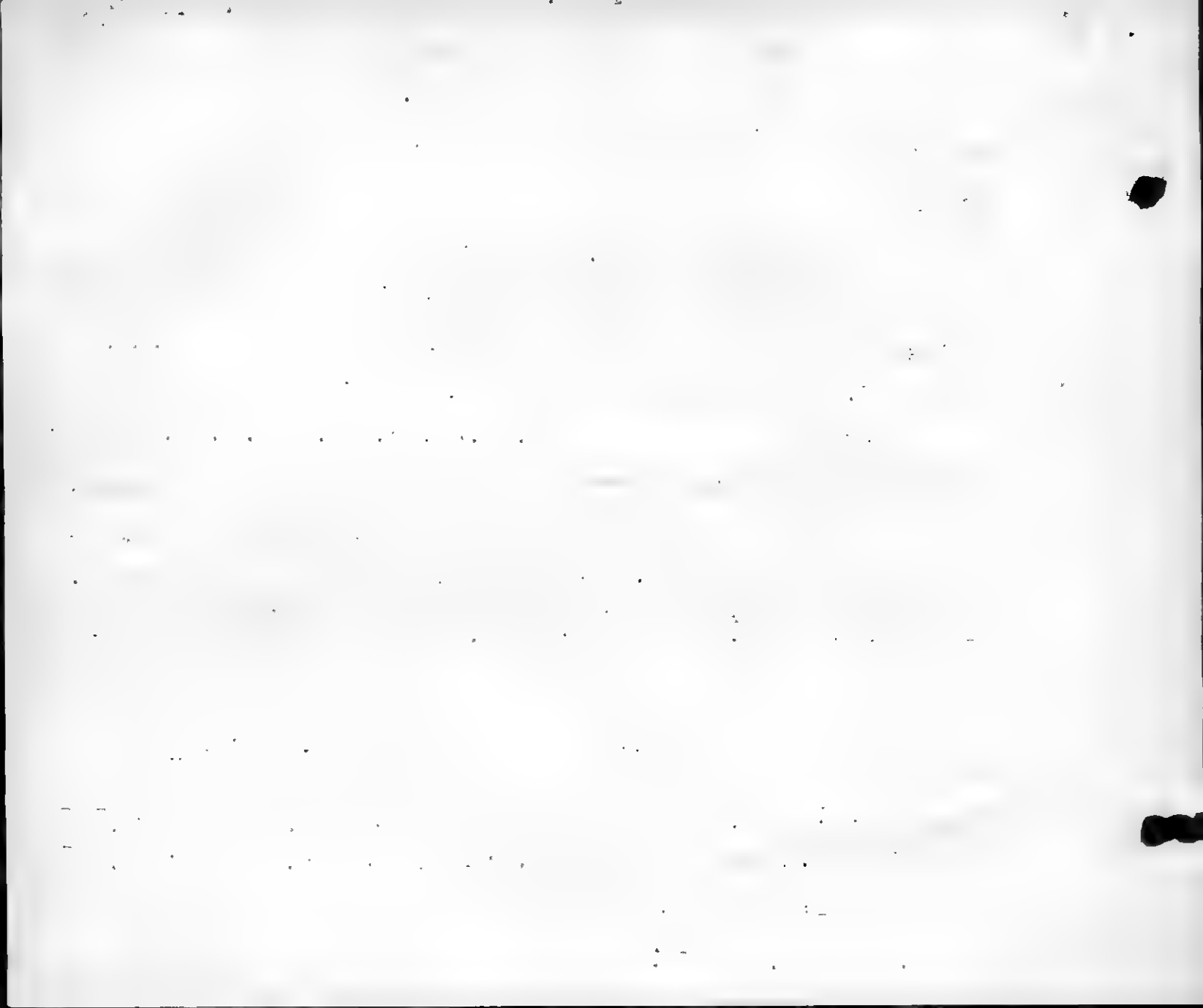
CERTIFICATE OF DEATH

13397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 15 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 4308 Mainfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last KEES				4. DATE OF DEATH Month DECEMBER Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 1891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Liquor		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHRISTIAN J. KEES				14. MOTHER'S MAIDEN NAME BETTY SCHMITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW I		INFORMANT Address Clin. Rec. Vet. Adm. Hosp. Balto. Md. Ft. Howard Div			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE & ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) CHRONIC PYELONEPHRITIS WITH UREMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND T. ONLY GIVEN IN PART I (c) Myocardial Infarction, Old; Bronchopneumonia, left lower lobe; Abscess right scrotum; Generalized Arteriosclerosis.						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 18, 1959 to December 19, 1959 , and that death occurred at 7:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. Ft. Howard Div. DATE SIGNED 12-19-59 ACTUAL SIGNATURE Joseph J. Cillo M.D. VAH, Baltimore, Md. Ft. Howard Div. DATE SIGNED 12-19-59 PHYSICIAN'S NAME (Type) Joseph J. Cillo M.D. VAH, Baltimore, Md. Ft. Howard Div.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-59		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc., Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneal	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13421

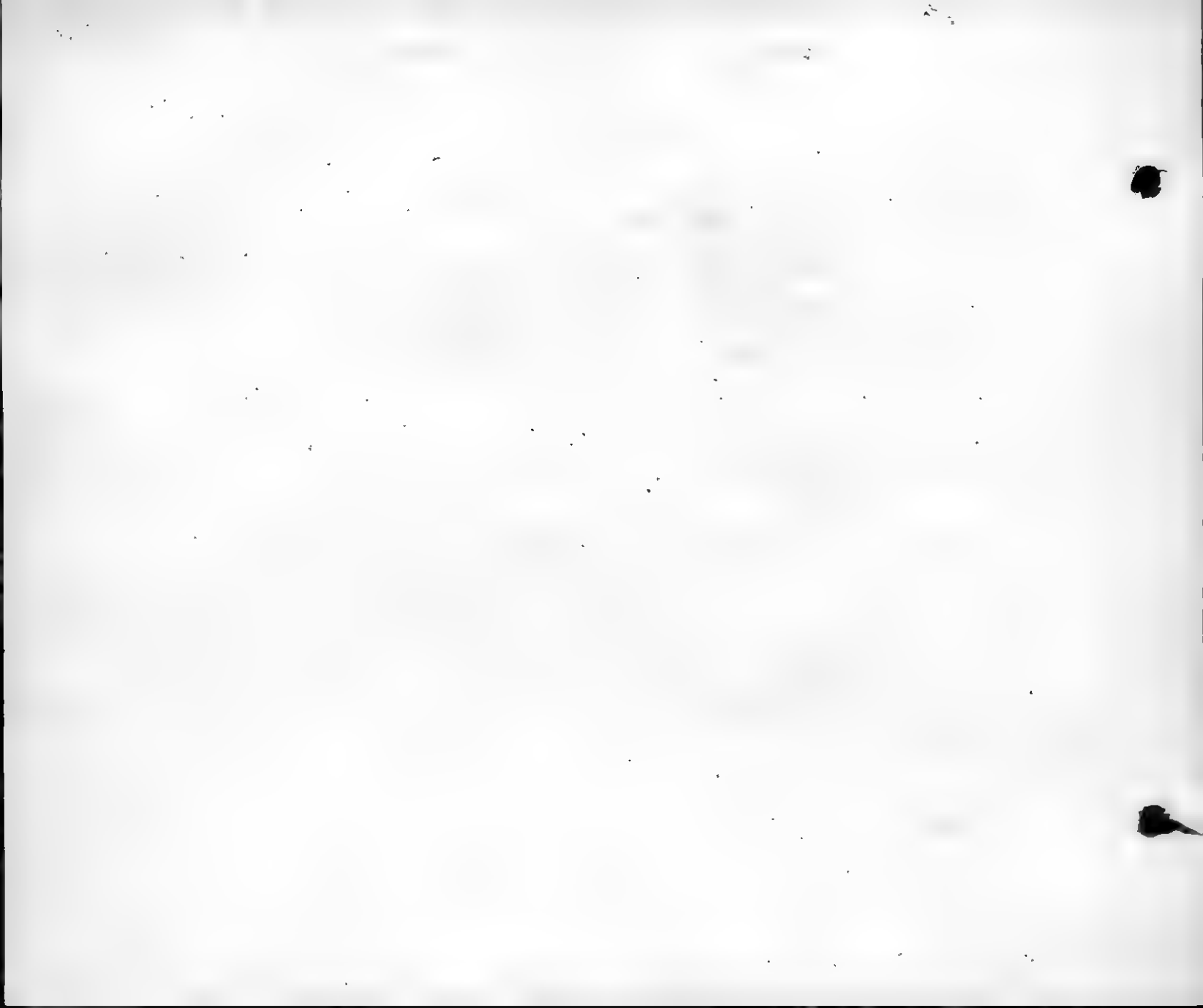
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>212 Blikney Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>KESTLER</u> Last <u>KESTLER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier Post Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Kestler</u>			
14. MOTHER'S MAIDEN NAME <u>George</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mamie E. Kestler</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4+ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u> <u>12 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a</u> m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/23</u> 19 <u>59</u> to <u>12/30</u> 19 <u>59</u> that I last saw the deceased alive on <u>12/30</u> 19 <u>59</u> , and that death occurred at <u>11:33</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eli W. Johnson</u>				ADDRESS (Street, city or town, state) <u>3432 Frederick Ave Baltimore 29 Md</u>			
PHYSICIAN'S NAME (Type) <u>Eli</u>				DATE SIGNED <u>12/31/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. [unclear] + Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

13422

CERTIFICATE OF DEATH

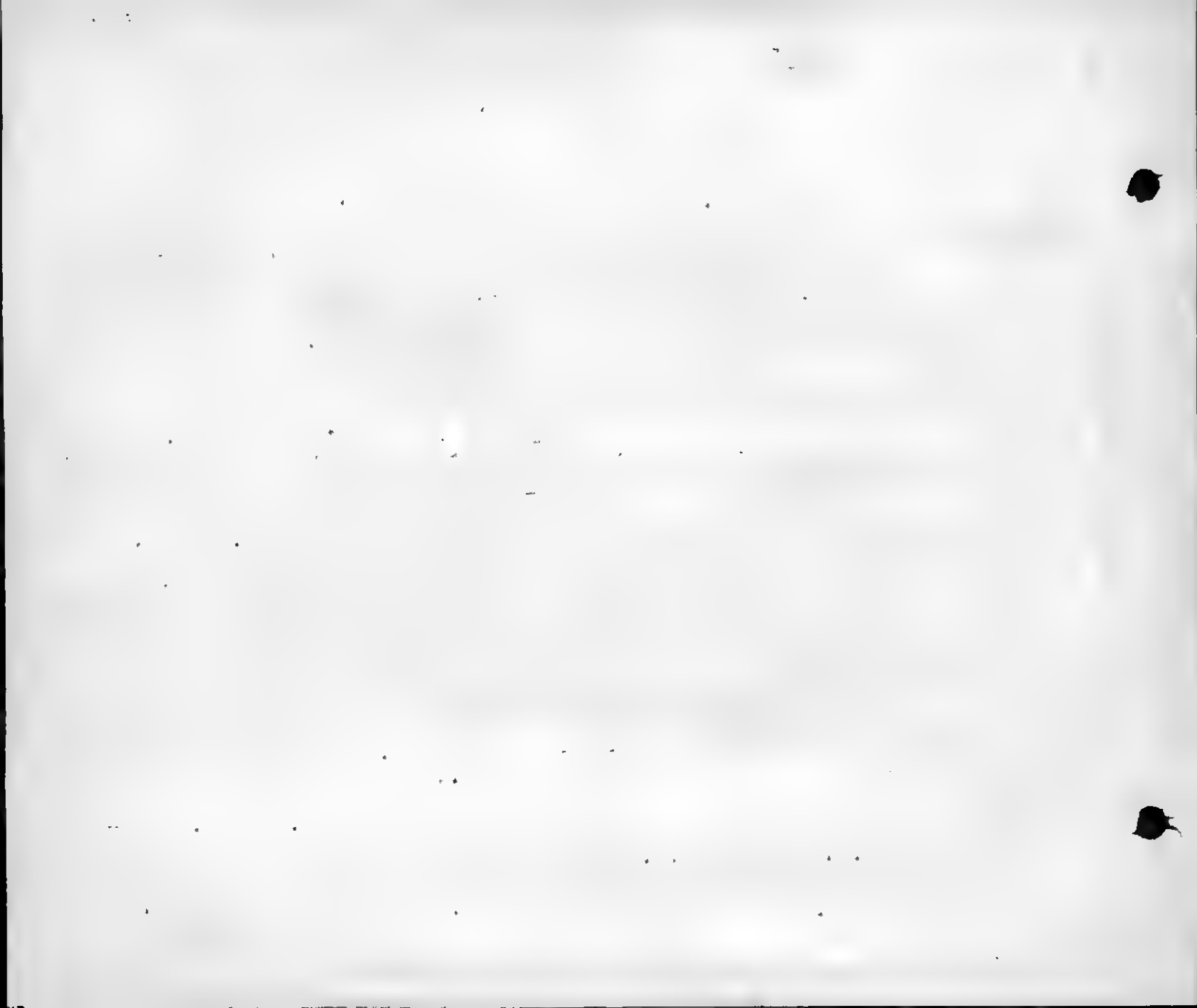
13399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Jones Ave.</u>				d. STREET ADDRESS <u>5 Jones Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>KING</u> Last				4. DATE OF DEATH Month <u>DEC.</u> Day <u>19,</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cooksville Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Cooksville Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Dennis Sands</u>				14. MOTHER'S MAIDEN NAME <u>Annie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Volatta Johnson</u> Address <u>5 Jones Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral Insufficiency</u> I Yr. II Mo. <u>10</u> Days <u>10</u> DUE TO (c) <u>Hypertensive- Arterio-sclerotic Heart Dis.</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>I-22-</u> <u>1958</u> , to <u>Dec. 19th., 1959</u> , that I last saw the deceased alive on <u>12-19th</u> <u>1959</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Winters Lane. Balto.</u> DATE SIGNED <u>28-12-19-59</u> ACTUAL SIGNATURE <u>C.F. Maloney M.D.</u> PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>West Liberty Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie Williams</u> ADDRESS <u>322 N. Schneider St.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13400

Item 3 Film 254 1-13-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward First Franklin Middle Klein Last		4. DATE OF DEATH December 26th 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Klein		14. MOTHER'S MAIDEN NAME Caroline Roeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Emil G. Forthuber, Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Sudden Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles West C'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles West C'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/29/59	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Road.		24a. REC'D BY REGISTRAR DEC 31 1959	24b. REGISTRAR'S SIGNATURE Colin S. Kead

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13401**

13424

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forrest Haven Nursing Home		d. STREET ADDRESS 1609 S. Charles Street #30	
3. NAME OF DECEASED (Type or print) First John Middle William Last Koch		4. DATE OF DEATH Month December Day 6 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Sinclair Scott Co. Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Koch		14. MOTHER'S MAIDEN NAME Christiane Heusler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-1483	
17. INFORMANT Frances C. Koch		Address 1609 S. Charles St. #30	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) POSSIBLE SECONDARY CARDIO-VASCULAR DISEASE DUE TO (c) DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1 , 19 59 to 12/6 , 19 59 , that I last saw the deceased alive on 11/6 , 19 59 , and that death occurred at 5:12 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Shaw		ADDRESS (Street, city or town, state) 5800 Edmondson Ave DATE SIGNED 11/7/59	
PHYSICIAN'S NAME (Type) John Shaw, M. D.		5800 Edmondson Avenue #18111	
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Anne Arundel County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

13425

CERTIFICATE OF DEATH

Reg. Dist. No. 13402

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V: 4-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 1634 EAST 31ST ST.	
3. NAME OF DECEASED (Type or print) First MARY Middle E Last KRAFT		4. DATE OF DEATH Month DEC Day 22 Year 1959	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1873
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LOUIS VOGTMANN		14. MOTHER'S MAIDEN NAME MARY HEUSI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr - Cockeysville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 19 Day 19 Year 1959 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15 , 19 47 , to 12-21 , 19 59 , that I last saw the deceased alive on 12-21 , 19 59 , and that death occurred at 3:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Kees		ADDRESS (Street, city or town, state) Cockeysville, Md	
PHYSICIAN'S NAME (Type) Walter T. Kees		DATE SIGNED 12/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-24-59	
22c. NAME OF CEMETERY OR CREMATORY 1st Evangelical Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DEC 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 253 12-10-59 et

CERTIFICATE OF DEATH

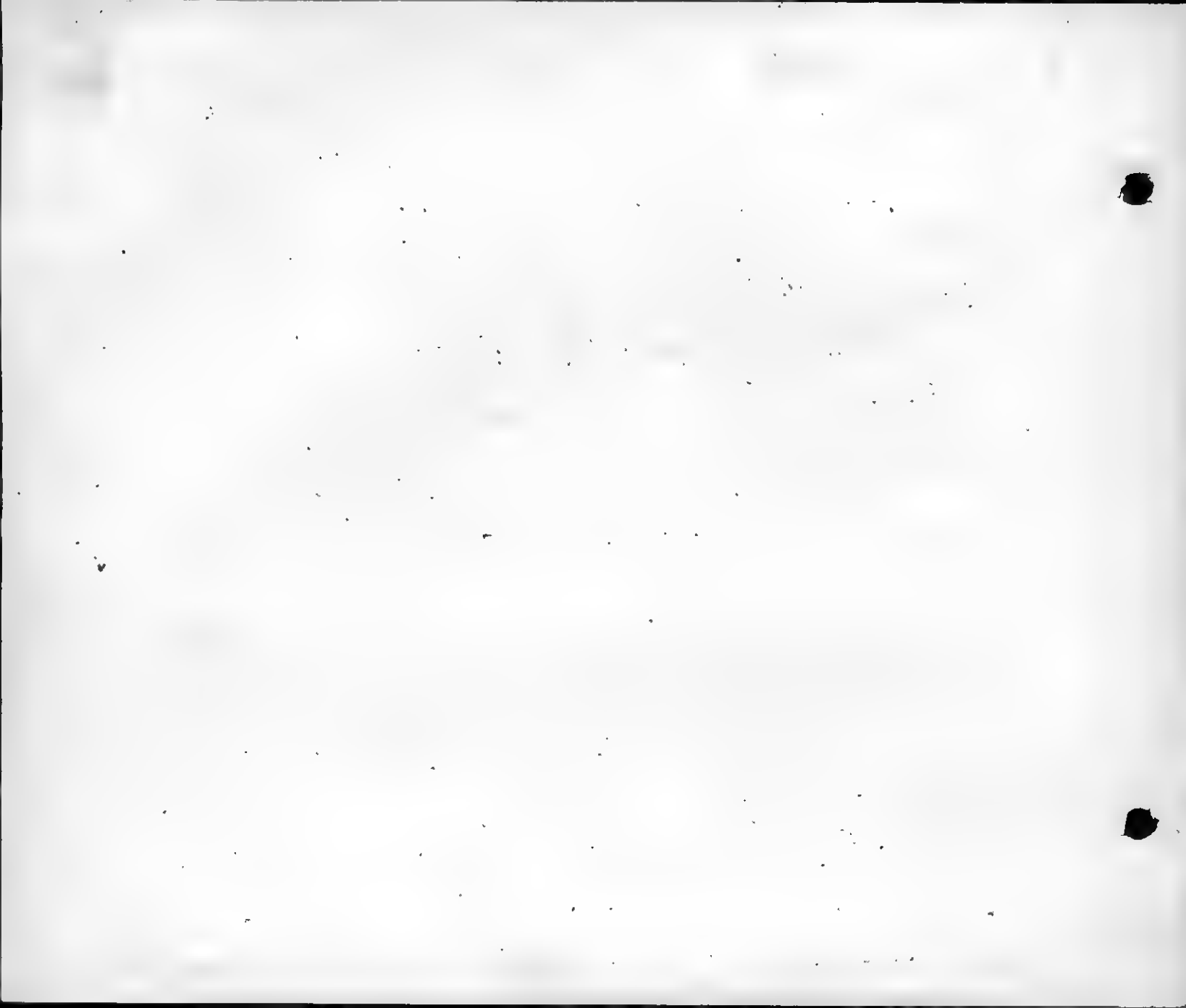
13403

13426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>420 Aigburth Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>E</u> Last <u>KRIES</u>		DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1889</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heating Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry A. Kries</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ida M. Kries - 420 Aigburth Rd - 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Feb. 28, 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6001 LOCH RAVEN BLVD</u>		20f. (City or town) (County) (State) <u>BALTIMORE - MD</u>	
21. I certify that I attended the deceased from <u>Feb. 28, 1959</u> to <u>Feb. 4, 1959</u> that I last saw the deceased alive on <u>Feb. 4, 1959</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo Schlenger</u>		DATE SIGNED <u>12/4/59</u>	
PHYSICIAN'S NAME (Type) <u>LEO SCHLENGER, M.D.</u>		ADDRESS (Street, city or town, state) <u>BALTIMORE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. COOK-TOWSON, INC - TOWSON, MD</u>		24a. REC'D BY REGISTRAR <u>DEC 7 1959</u>	
ADDRESS <u>W. COOK-TOWSON, INC - TOWSON, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

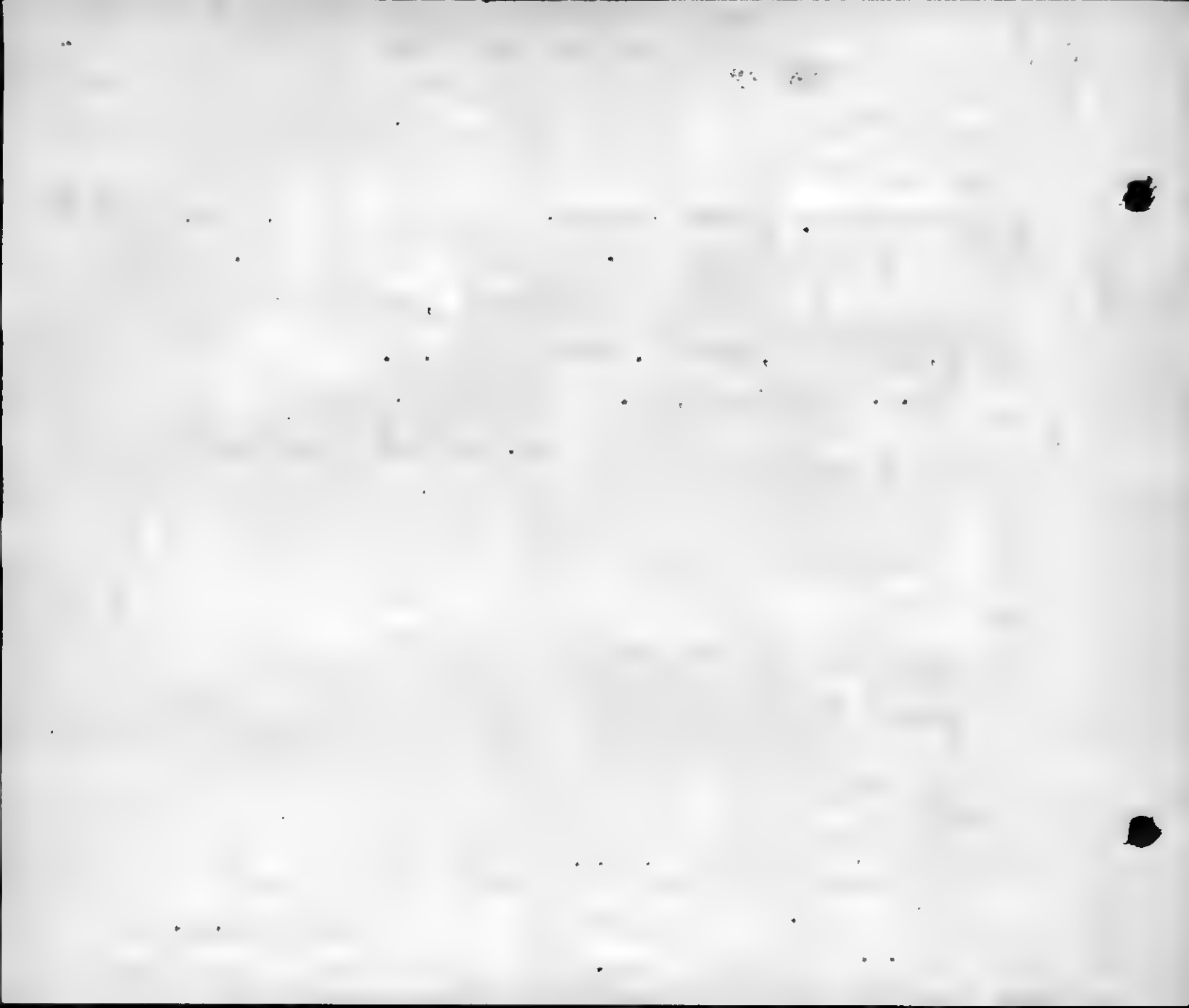
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In street in front of 6104 Mt. Ridge Rd.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 6104 Mt. Ridge Rd. Balt. 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Langenfelder Jr. (Type or print) George Langenfelder Jr.		4. DATE OF DEATH Month Dec. Day 20 Year 1959	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1918
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner, Meat Stall, Cross St. Market	11. BIRTHPLACE (State or foreign country) Balt. Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Geo. A. Langenfelder, Sr.	
14. MOTHER'S MAIDEN NAME Dorothy S. Grady		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215 01 6848		17. INFORMANT 6104 Mount Ridge Road Mrs. Florence Evelyn Langenfelder	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of chest (2), with massive hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by assailant	
20c. TIME OF INJURY Month, Day, Year 12/20/59	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Catonsville		(County) Baltimore (State) Me.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED December 20, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please advise the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No. 13405

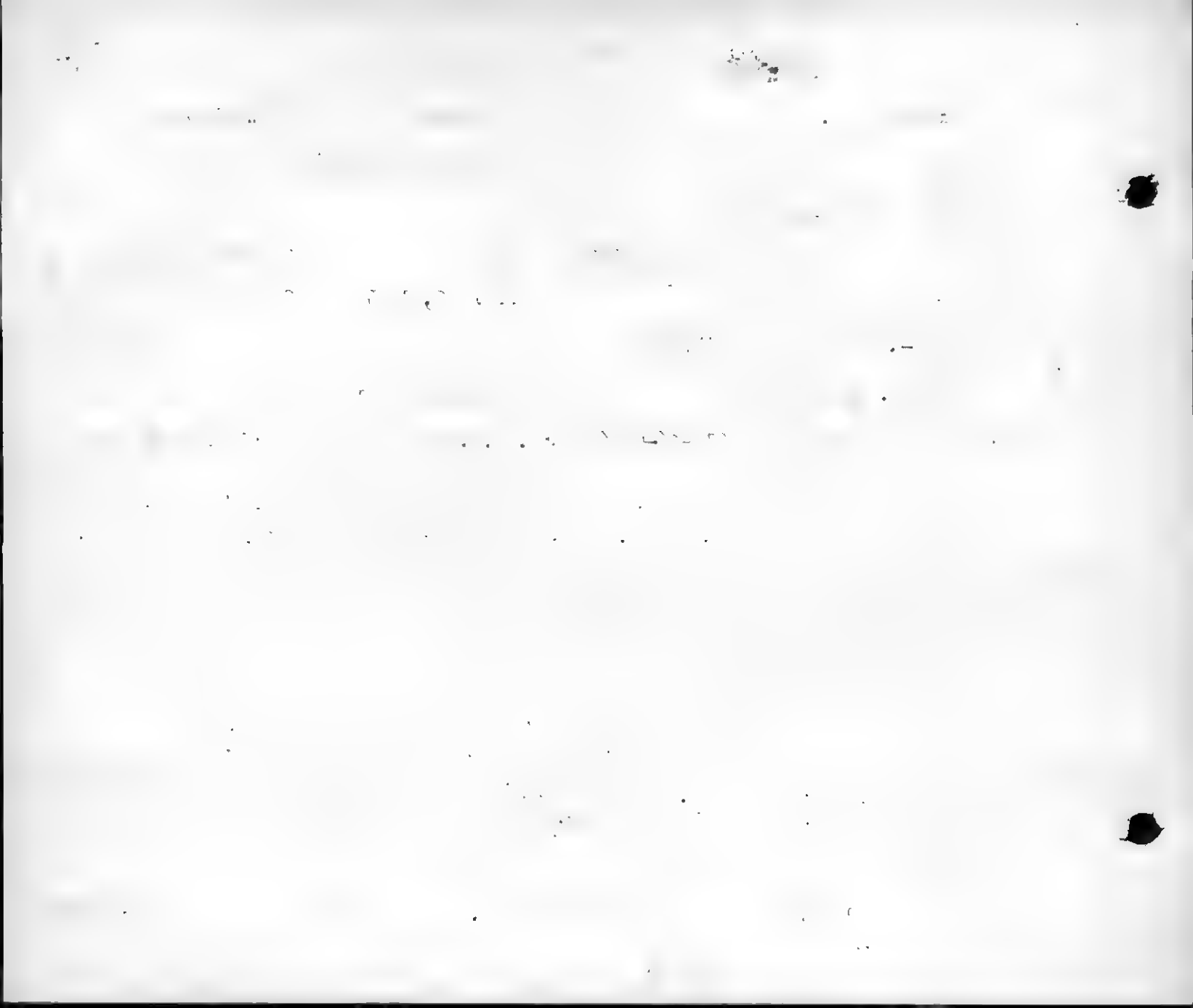
13428

1. PLACE OF DEATH a. COUNTY BALTIMORE CO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b TOWSON d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVELSCENT HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM LAU		4. DATE OF DEATH Month Day Year DECEMBER 6 19 59	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1877
9. AGE (in years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MINISTRY	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KARL W. LAU		14. MOTHER'S MAIDEN NAME CHRISTINA vonBOHR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 218-36-0666	
17. INFORMANT MRS. C.W. LAU		Address 402 ALABAMA ROAD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 19 59 to Dec 6 19 59 that I last saw the deceased alive on December 6, 19 59 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles W. Lau M.D.			
ACTUAL SIGNATURE Charles W. Lau			
PHYSICIAN'S NAME (Type) Charles W. Lau			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/9/59	
22c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GARDEN		22d. LOCATION (City, town, or county) (State) TIMONIUM MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		24a. REC'D BY REGISTRAR DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13429

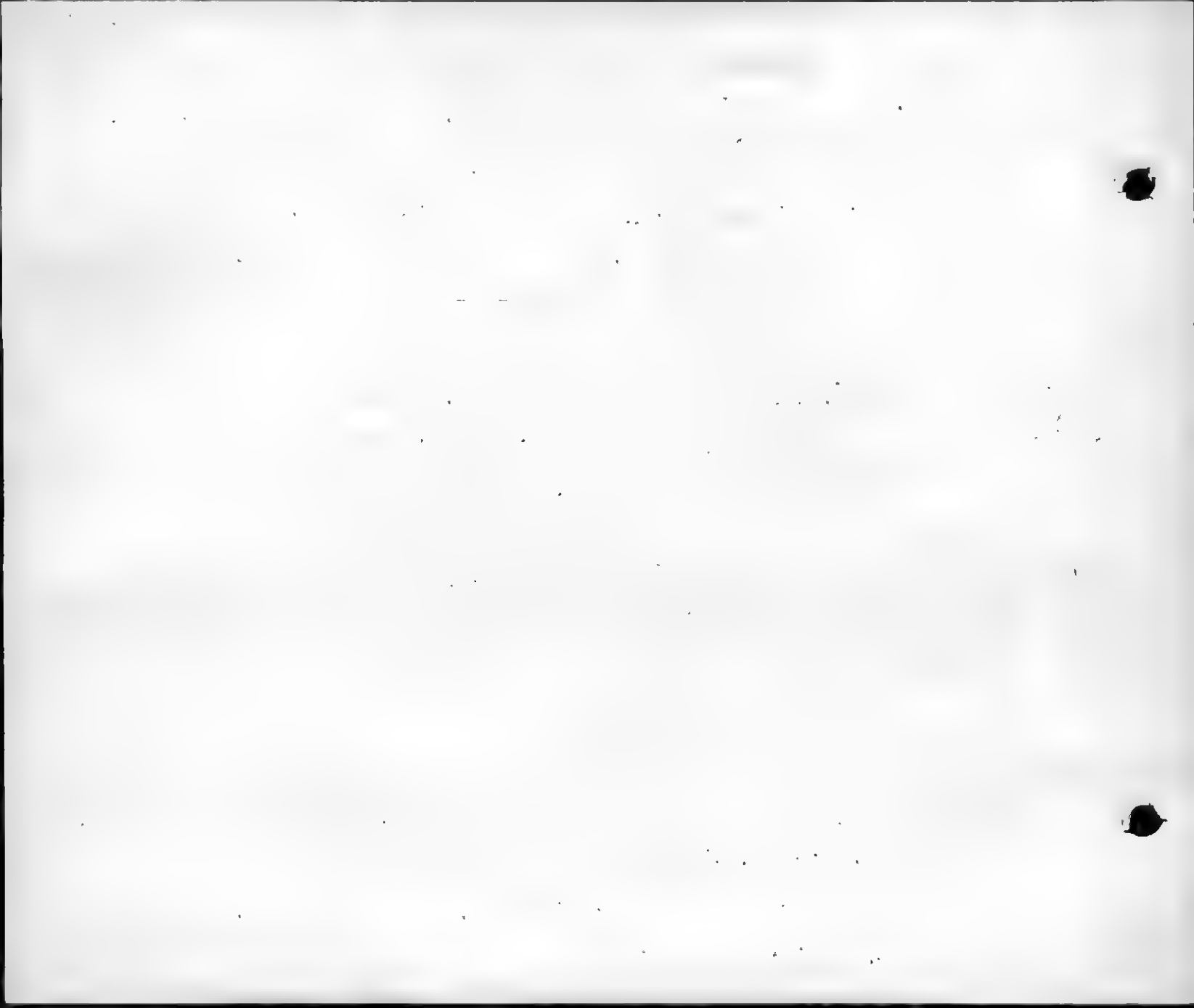
CERTIFICATE OF DEATH

Reg. Dist. No.

13406

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>224 Spring Ave.</u>		d. STREET ADDRESS <u>224 Spring Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Leach</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>15</u> Min <u>00</u>	11. IF UNDER 24 HRS Hours <u>15</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles J. Itzel</u>		14. MOTHER'S MAIDEN NAME <u>S. Franklin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Walter E. Leach</u>	
17. INFORMANT <u>Walter E. Leach</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Hypertensive arteriosclerotic Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 25</u> , 19 <u>59</u> , and that death occurred at <u>6:4</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul G. Mueller</u>		ADDRESS (Street, city or town, state) <u>6411 Belair Rd</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Paul G. Mueller</u>		DATE SIGNED <u>12/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Texas, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13407

13430

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>133 Parkins St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY - LEE</u>		4. DATE OF DEATH Month Day Year <u>December 30 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 28, 1891</u>
9. AGE (In years lost birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Lee</u>		14. MOTHER'S MAIDEN NAME <u>Ida Smathers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital Balto 18, Md</u>		Address <u>Fort Howard Div.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM WITH GENERALIZED METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>EDEMA OF THE LUNGS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Active fibro-caceous tuberculosis left upper lobe</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 15, 19 59</u> to <u>December 30, 19 59</u> and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH Balto 18, Md Ft Howard Div</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>John W Crawford</u> M.D. <u>VAH Balto 18, Md Ft Howard Div</u> PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u> <u>VAH Balto 18, Md Ft Howard Div</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 4, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S Phillips 1808 N Monroe St Balto Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina L. Thomas</u>			

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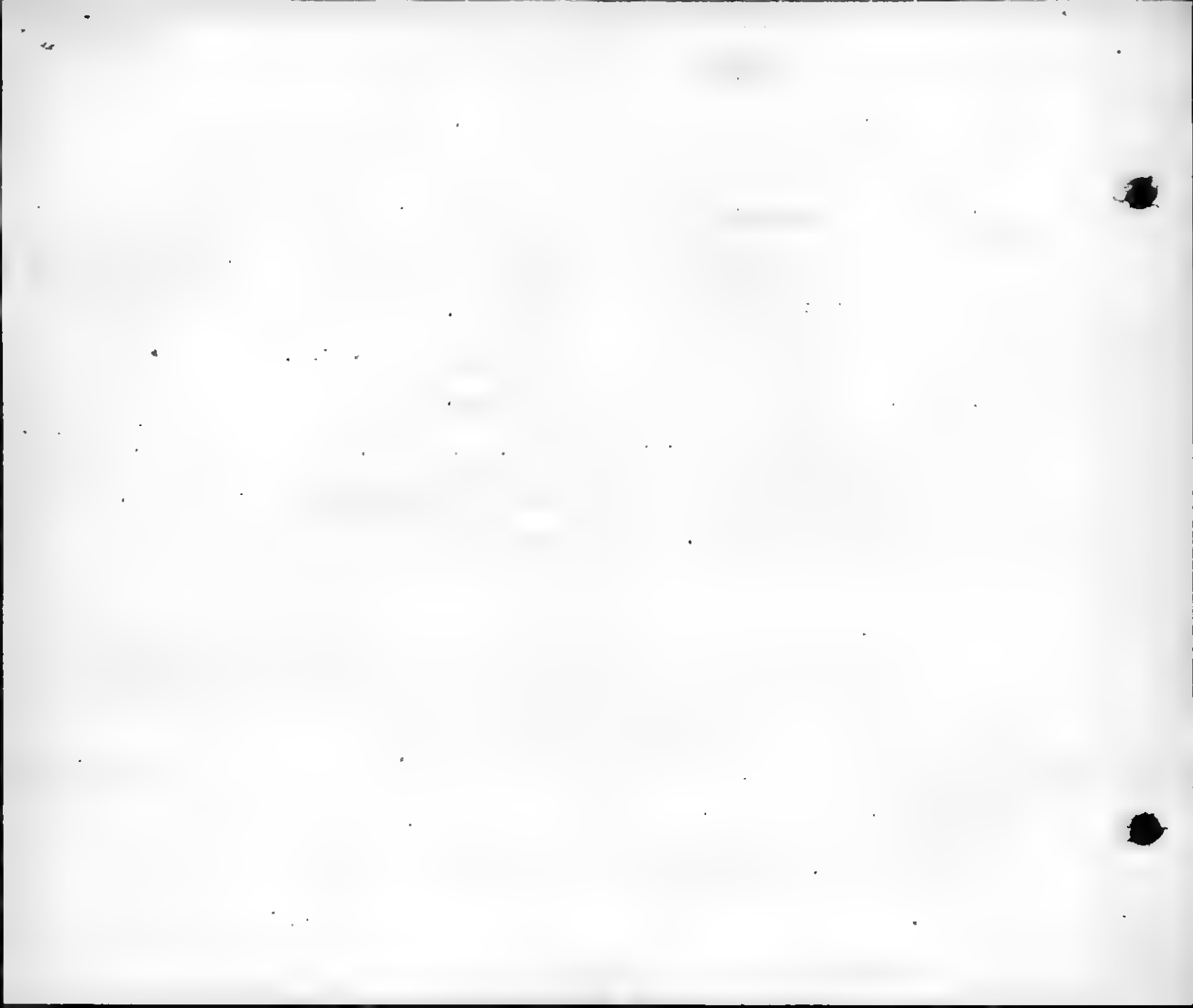
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TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

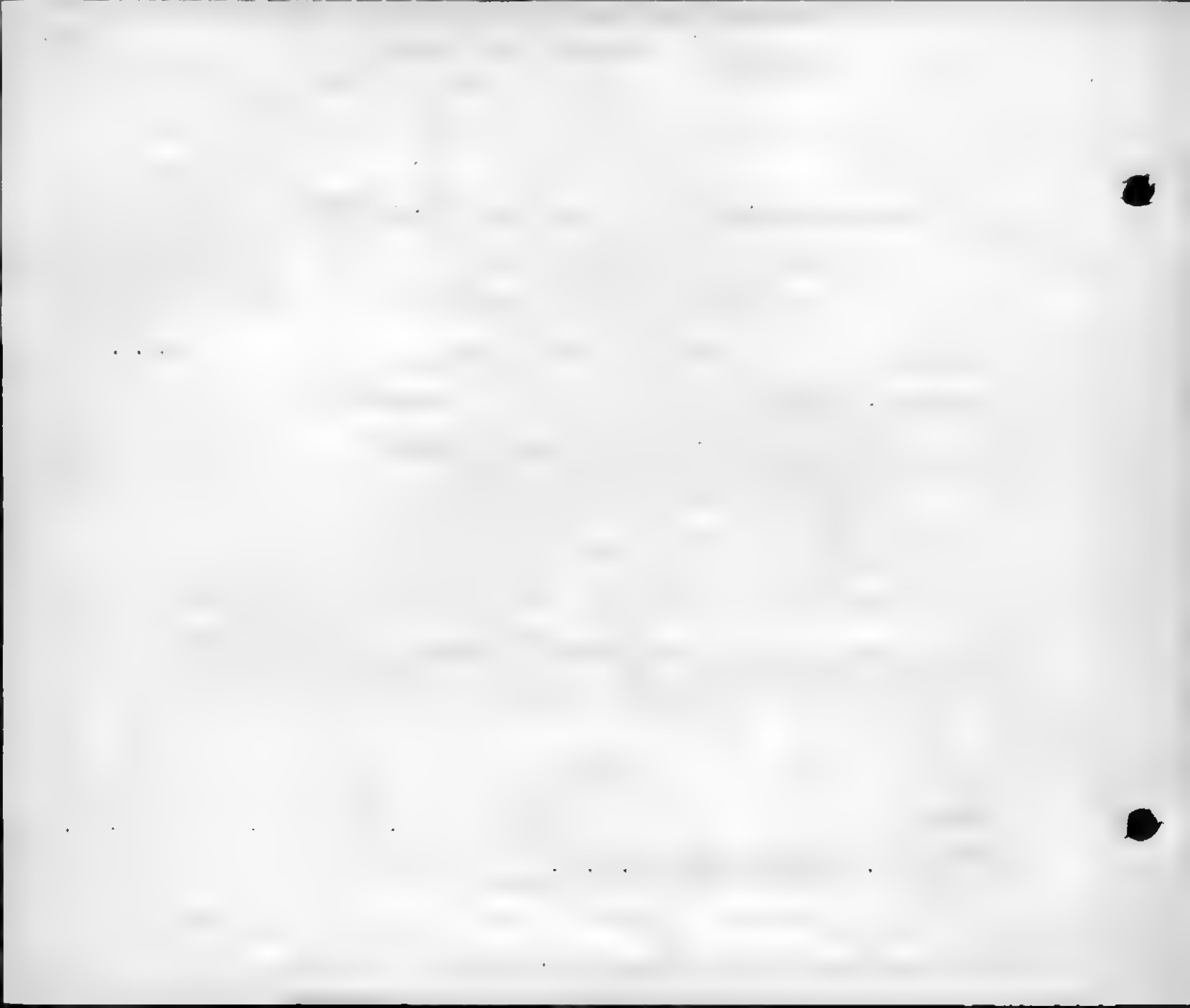
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13408

13431

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd. - Hereford</u>		d. STREET ADDRESS <u>York Rd. - Hereford</u>	
3. NAME OF DECEASED (Type or print) <u>Emory Charles Leight</u>		4. DATE OF DEATH <u>12/19/59</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Leight</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-20-9733</u>	
17. INFORMANT <u>Elwood Leight</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1/59</u> , 19____, to <u>12/19/59</u> , 19____, that I last saw the deceased alive on <u>12/10/59</u> , 19____, and that death occurred at <u>2:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. Herbert Mueller, Jr.</u> M.D.		ADDRESS <u>York Rd. Parkton, P.O. Hereford, Md.</u> DATE SIGNED <u>12/23/59</u>	
PHYSICIAN'S NAME (Type) <u>C. Herbert Mueller, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	



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13432

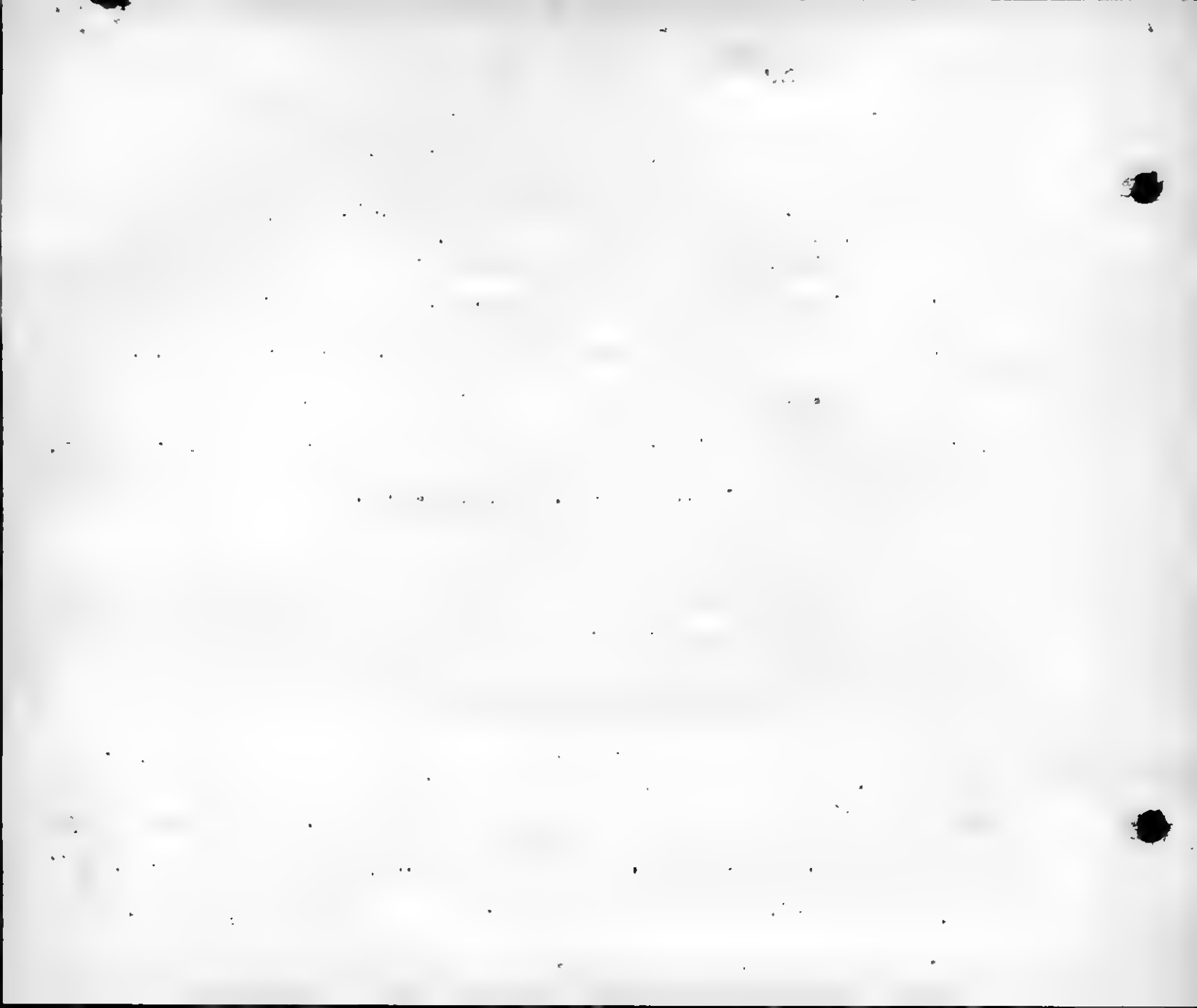
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13409

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 96 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Servedas: ALEX First D Middle D Last LIVINGSTON		4. DATE OF DEATH December 29 1959 Month December Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Harford Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John G Livingston		14. MOTHER'S MAIDEN NAME Katherine Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 705-10-1913	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE RIGHT HEMISPHERE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Status post resection of carcinoma of the colon		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year VA Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21, 1959 to December 29, 1959 and that death occurred at 1:10 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH BALTO 18, MD FT HOWARD DIV DATE SIGNED 12/30/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH BALTO 18, MD FT HOWARD DIV 12/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/1959	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J Ruck		24a. REC'D BY REGISTRAR DEC 31 '59 24b. REGISTRAR'S SIGNATURE Carl S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13336

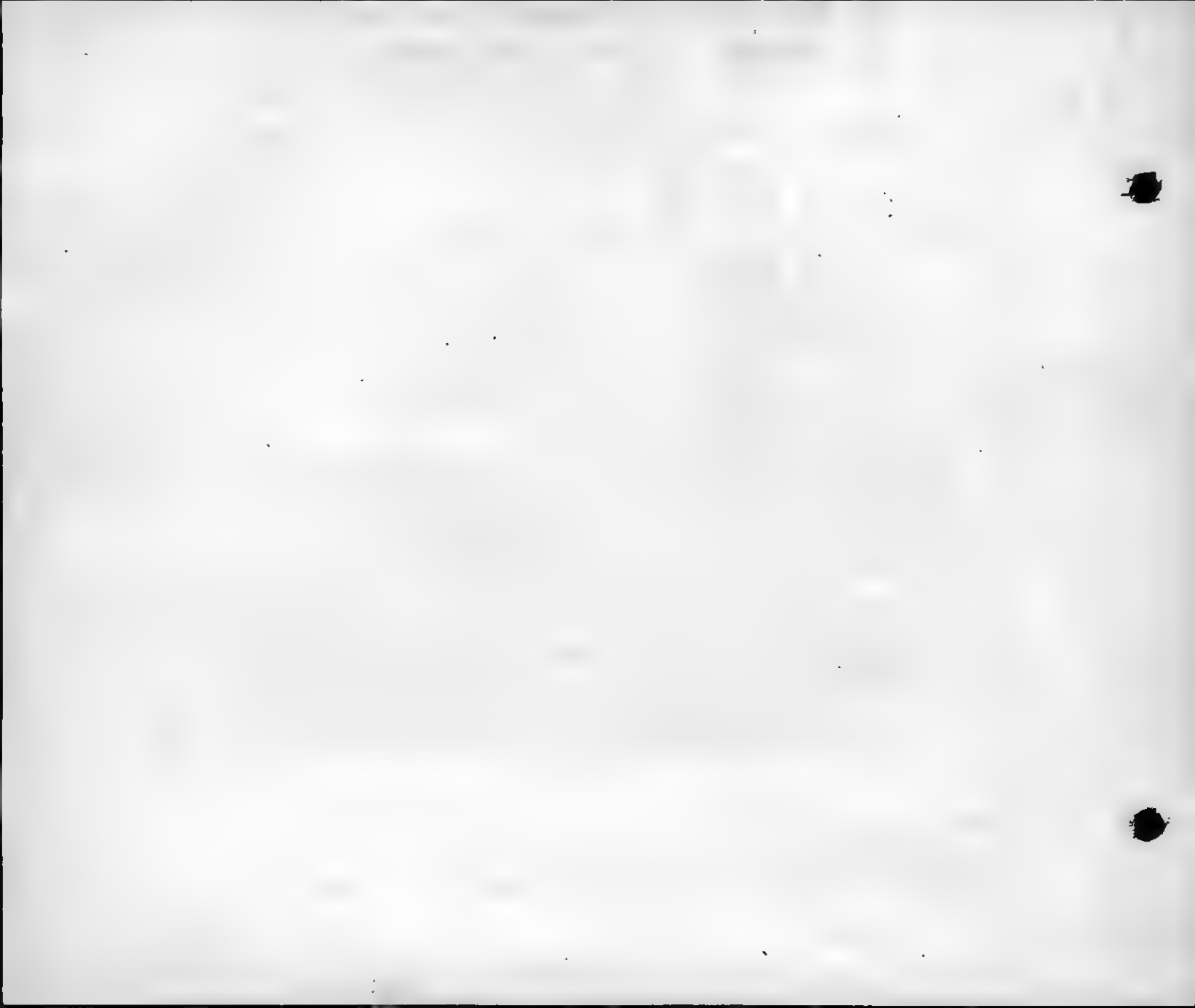
CERTIFICATE OF DEATH

Reg. Dist. No.

13410

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANS DOWNE				c. LENGTH OF STAY IN 1b 27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 243 SECOND AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle R. Livingston Last 4. DATE OF DEATH DEC 15 1959				5. SEX FEMALE 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 770X 1891 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adm.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) BALTO Md				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Walz				14. MOTHER'S MAIDEN NAME HITZELBERGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE 17. INFORMANT VIRGINIA C BAUGUS Address HANS DOWNE 243 SECOND AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatosis DUE TO (b) Carcinoma of Cervix DUE TO (c) metastatic CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH July 1958			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/17 1959 to 10/15 1959 , that I last saw the deceased alive on 11/10 1959 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eliot W. Johnson				ADDRESS (Street, city or town, state) 34320 Redwood Ave Baltimore Md DATE SIGNED 12/10/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 17 DEC 1959		22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEM		22d. LOCATION (City, town, or county) (State) A. A. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. M. Walters				24a. REC'D BY REGISTRAR DEC 17 '59			
ADDRESS 1111 Cr. B. M. Walters				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13411

13433

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>29 Helrey Ave</i>				d. STREET ADDRESS <i>29 Helrey Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Matthew F. Martin</i>				4. DATE OF DEATH <i>Dec 13 1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/18/83</i>	9. AGE (In years last birthday) <i>76</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Spring Grove State Hosp - ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown to family records</i>				14. MOTHER'S MAIDEN NAME <i>unknown to family records</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>216 346137</i>		17. INFORMANT <i>C. M. Martin - Parkton Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis</i> 153.8 DUE TO <i>Carcinoma Sigmoid Colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>4 1/2 years</i> (c)				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <i>11/17</i> , 19 <i>57</i> , to <i>12/13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/12</i> , 19 <i>57</i> , and that death occurred at <i>5:00A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eliot W. Johnson</i>				M.D. <i>Eliot W. Johnson</i>		DATE SIGNED <i>12/14/59</i>	
PHYSICIAN'S NAME (Type) <i>ELIOT W. JOHNSON M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McMurt + Son</i> ADDRESS <i>28</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13434

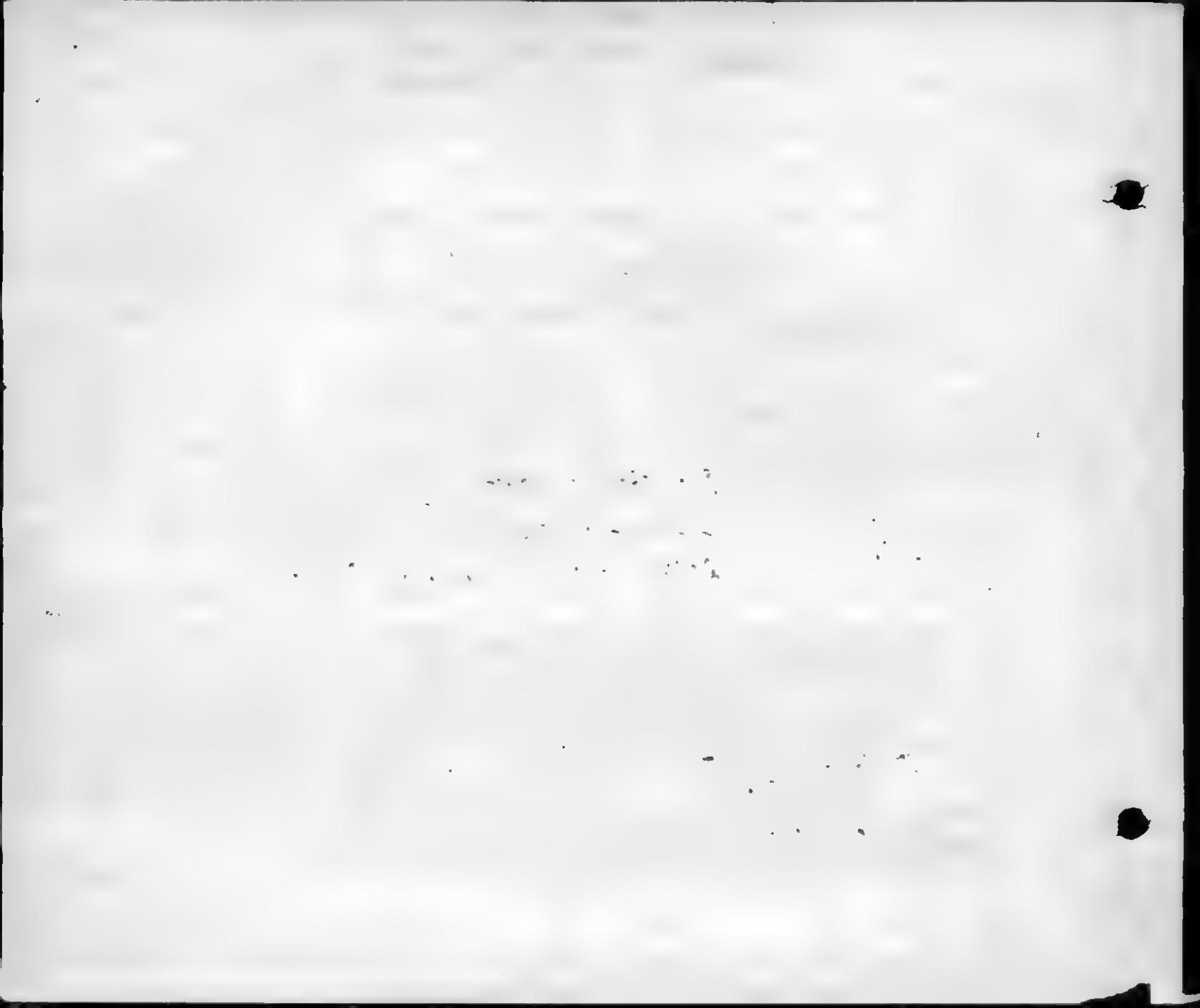
CERTIFICATE OF DEATH

Reg. Dist. No.

13412

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>31yr10mth6dys</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights, Maryland</u> d. STREET ADDRESS <u>Linthicum Heights, Md.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Eletta</u> Middle <u>Martinol</u> Last <u>June</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1959</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Antonia Satti</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Vincenti</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknwn</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>4500.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). <u>NOTING THE UNDERLYING CAUSE LOST.</u> (b) <u>GENERAL DEBILITY</u> DUE TO (c) <u>ARTERIOSCLEROTIC VASCULAR DISEASES</u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 29, 1959</u> to <u>Dec. 23, 1959</u> that I last saw the deceased alive on <u>Dec. 23, 1959</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>P. K. Yip</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>P. K. Yip M.D.</u> <u>Catonsville 28, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>26 DEC. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert P. Cebus - Glen Burnie, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X 1-3
FOR STATE
HEALTH DEPT.
M

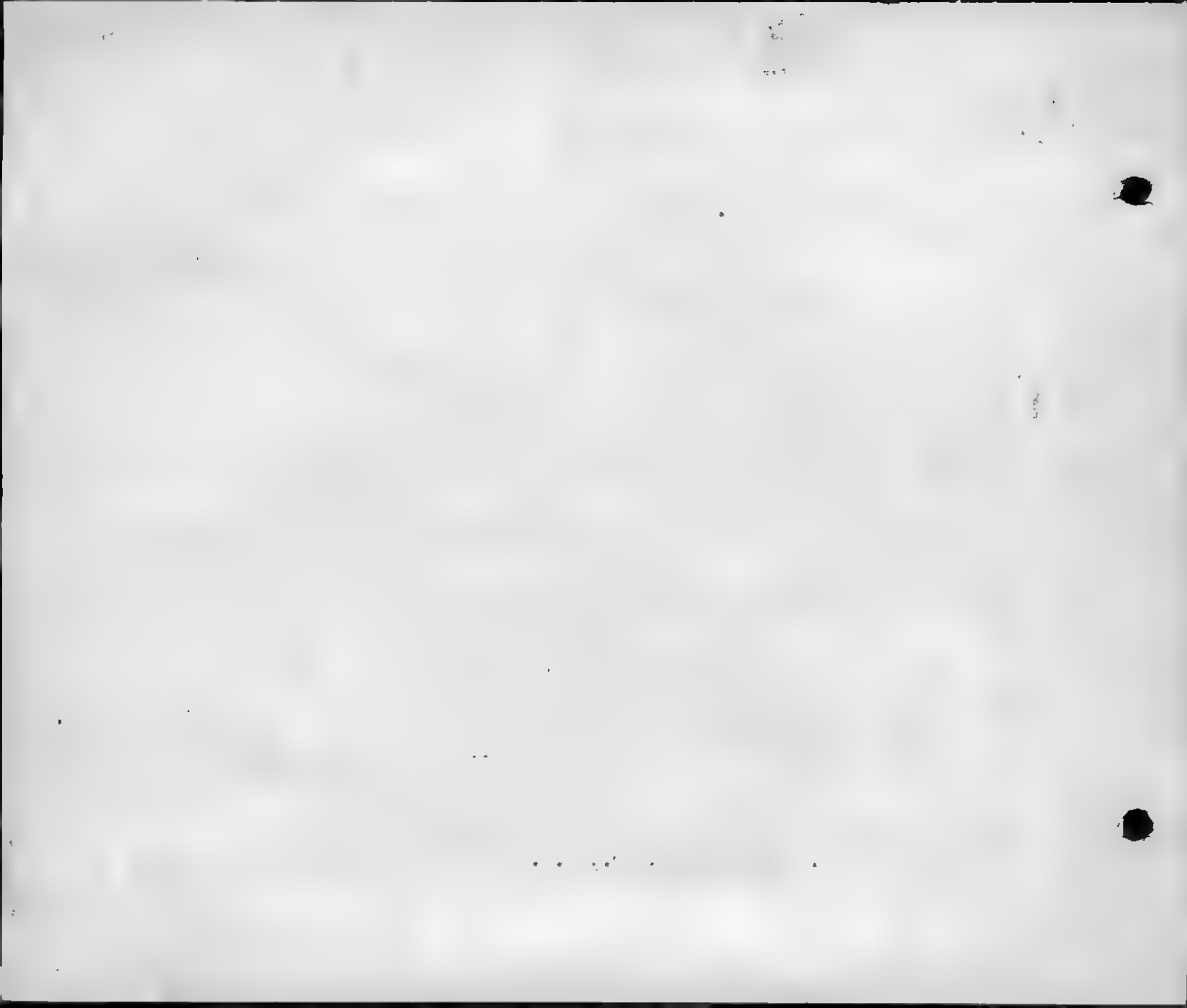
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OVERLEA c. LENGTH OF STAY IN b. LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7128 Greenwood Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OVERLEA d. STREET ADDRESS 7128 Greenwood Rd.					
3. NAME OF DECEASED (Type or print) CHRISTOPHER AUGUST MASER					4. DATE OF DEATH Month December Day 4 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 23, 1915		9. AGE (in years last birthday) 44 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST			10b. KIND OF BUSINESS OR INDUSTRY KOPPERS COMPANY			11. BIRTHPLACE (State or foreign country) BALTO MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH MASER					14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO					16. SOCIAL SECURITY NO. 217-09-7358					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Suffocation by plastic bag over head (c) Suffocated by plastic bag over head PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suffocated by plastic bag over head					
20c. TIME OF INJURY Month, Day, Year Hour Unknown m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE W. Bradley King, Jr.					M.D. W. Bradley King, Jr., M.D.					
EXAMINER'S NAME (Type)					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF DEC 7, 1959		22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		22d. LOCATION (City, town, or country) (State) FULLERTON MARYLAND			
23. FUNERAL DIRECTOR Sassad Funeral Home					ADDRESS 7401 Belair Road #6		24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

13413



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9. Film 4-254 1-6, 60.cac.

13436

CERTIFICATE OF DEATH

13414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND.		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 Ingleside Ave.</u>		e. STREET ADDRESS <u>306 Ingleside Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Edith</u> First <u>J. MASON</u> Middle Last		4. DATE OF DEATH <u>Dec. 27</u> 19 <u>59</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Smith</u>		14 MOTHER'S MAIDEN NAME <u>Sallie Engler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>Mrs. Edgar D. Galvin</u> Address <u>5922 CHARNWOOD (28) Rd.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Myocardial Degeneration</u> DUE TO (c) <u>Arterio-sclerotic Nephrosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic Nephrosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1957</u> to <u>27 Dec 1959</u> , that I last saw the deceased alive on <u>27 Dec 1959</u> , and that death occurred at <u>12:16 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D. ADDRESS (Street, city or town, state) <u>4605 Hammond Ave</u>		DATE SIGNED <u>27 Dec 59</u>	
PHYSICIAN'S NAME (Type) <u>William J. Bryson M.D.</u>		<u>Balto 29</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDEN PARK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u> ADDRESS <u>3512 Frederick Ave. (29)</u>		24a REC'D BY REGISTRAR <u>DEC 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13415

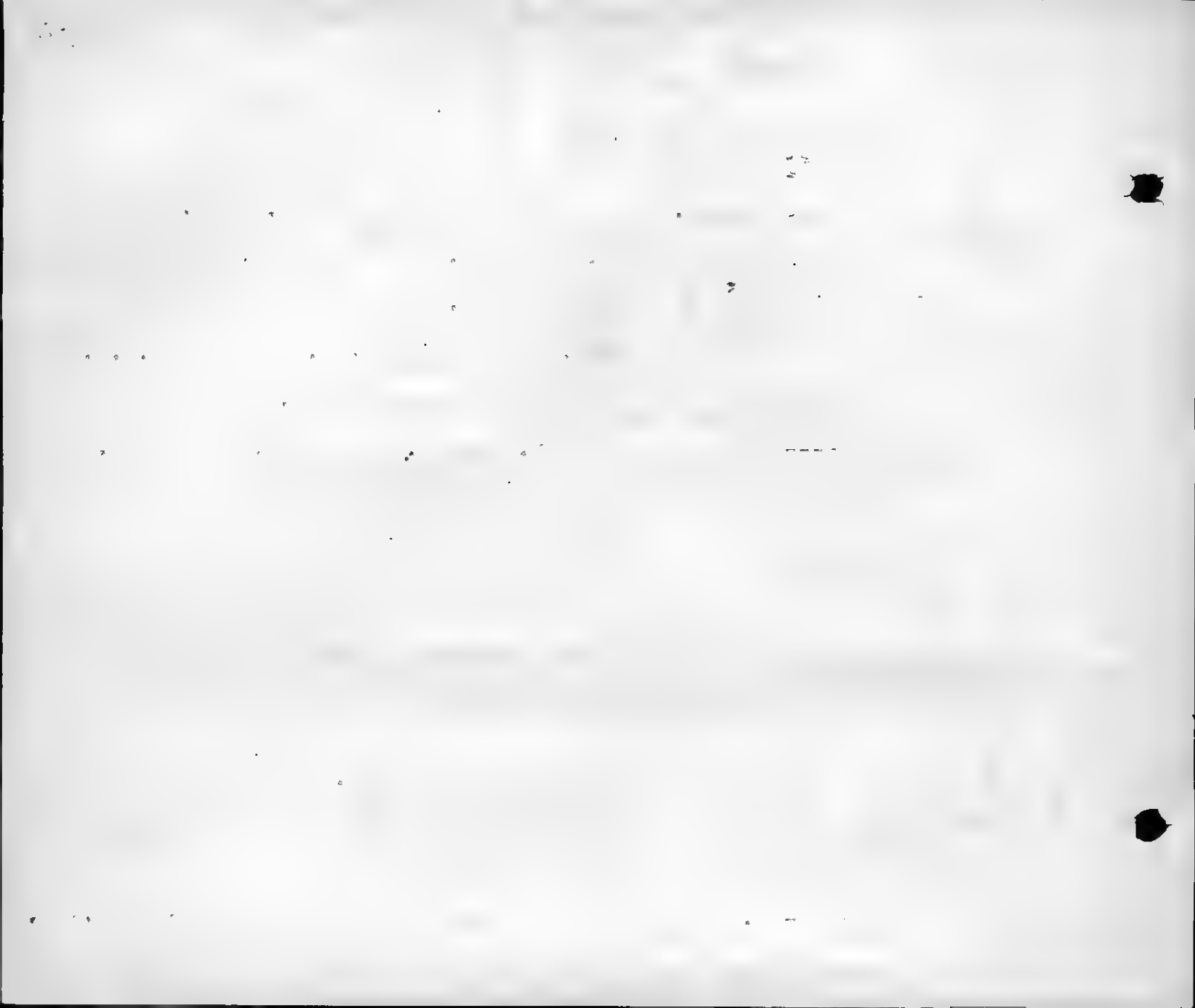
13437
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7234 Conley St. # 24.		d. STREET ADDRESS 3717 Fait Ave. # 24.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last MAY.		4. DATE OF DEATH Month December Day 30 Year 19 59.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1888
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Kohles		14. MOTHER'S MAIDEN NAME Barbara Hahn.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rev. James A. May C. SS. R.		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 199.2 DUE TO metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 1948 to Dec. 30, 1959 that I last saw the deceased alive on Dec 28, 1959 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3501 Fait Ave. Baltimore 24 DATE SIGNED			
ACTUAL SIGNATURE Edward A. Flanagan Jr. M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) EDWARD A. FLANIGAN JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-60.	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) (State) 4430 Belair Rd., Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geller		24a. REC'D BY REGISTRAR BALTO, 24, M.D.	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13416

13438

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 363 SAVANNAH AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ANNA Middle A Last MAYES		4. DATE OF DEATH Month 12 Day 31 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY-16-1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PINEHILL-NEW YORK		12. CITIZEN OF WHAT COUNTRY? U S A	

13. FATHER'S NAME CHARLES ROSA		14. MOTHER'S MAIDEN NAME LILLIAN BALDWIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ANTHONY MAYES Address (SAME AS ABOVE)			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO arter. Sclerotic Heart Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 yrs (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 16 hrs
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack C. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JACK C COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 1-1-60	22c. NAME OF CEMETERY OR CREMATORY WOODSTOCK CEM.	22d. LOCATION (City, town, or county) (State) WOODSTOCK NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
ADDRESS 418 Eastern Ave BALTO		24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

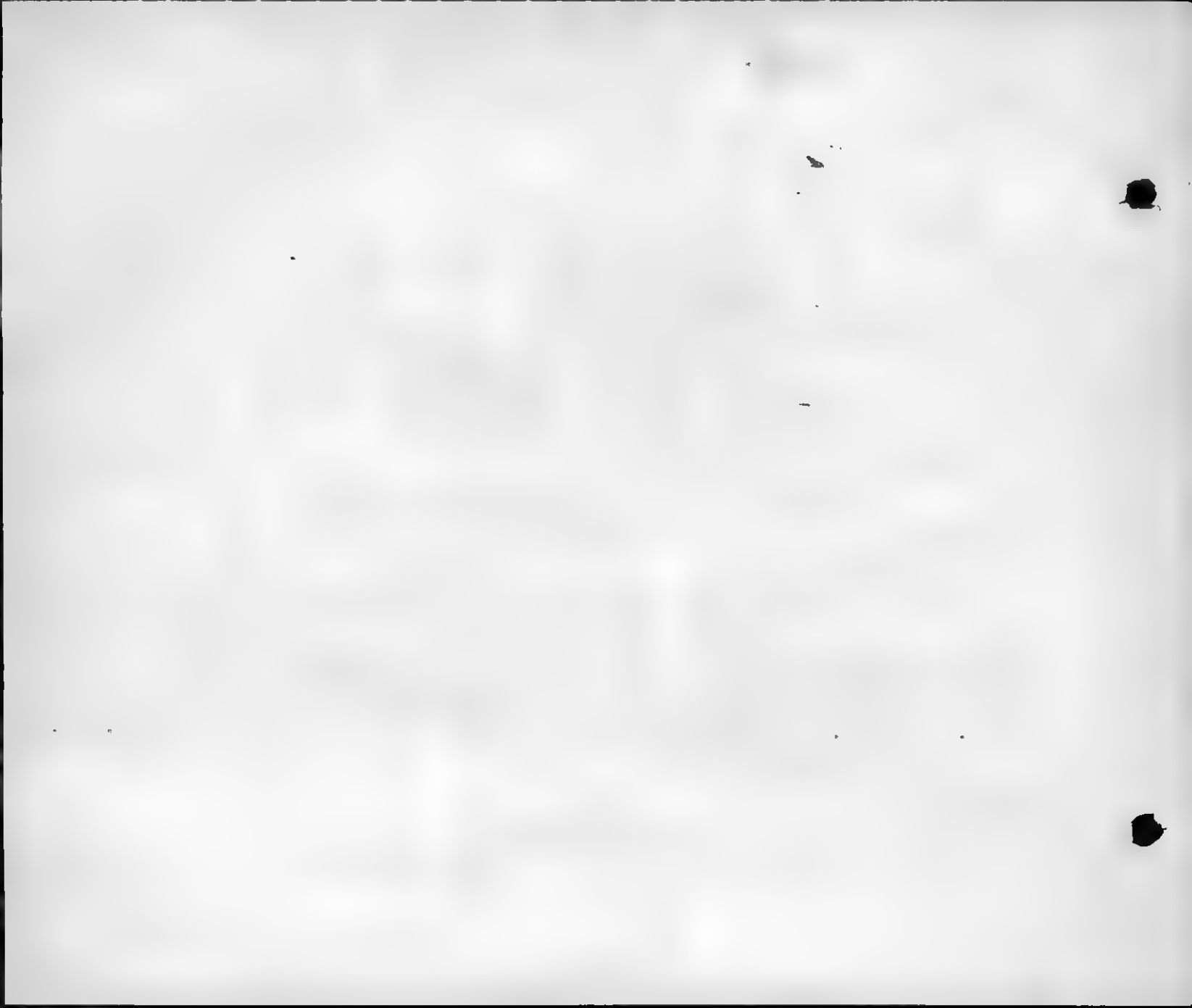
Reg. Dist. No.

13417

13435

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. LENGTH OF STAY IN 1b <u>5 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Hampstead</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beckleysville Rd.</u>				d. STREET ADDRESS <u>Beckleysville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert Lee Mays</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31/1945</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Hampstead Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert L. Mays</u>				14. MOTHER'S MAIDEN NAME <u>Melvia Bull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Albert L. Mays</u> Address <u>Hampstead Md. R.R.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture of the skull</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost, (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck a bridge abutment.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10.30</u> a. m. <u>Dec. 8</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Beckleysville, Balto., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>A. M. France</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hampstead Md. B.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Fortinching New-Freedom Pa.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

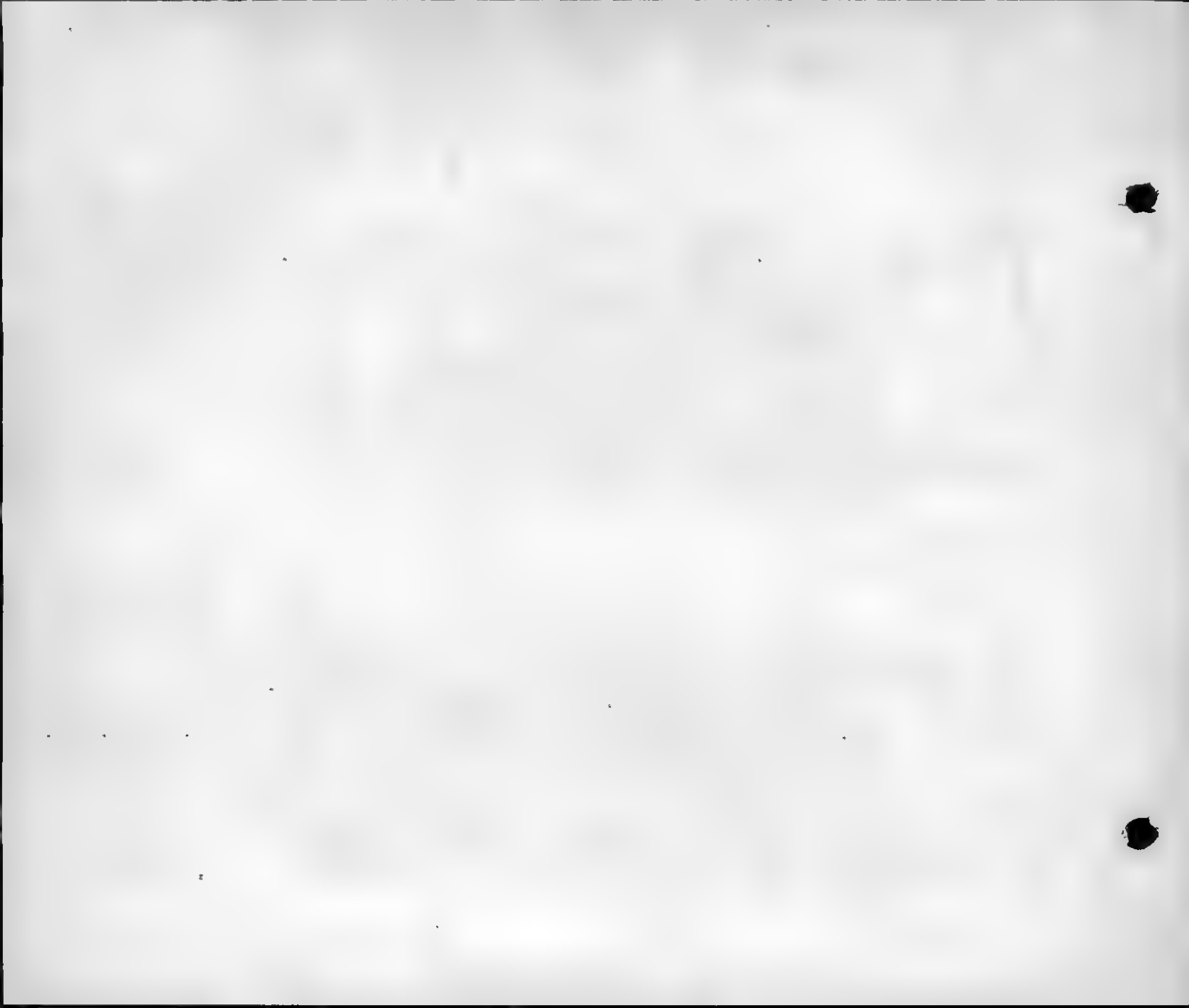
13418

13440

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. LENGTH OF STAY in 1b <u>5 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beckleysville Rd.</u>		d. STREET ADDRESS <u>Beckleysville.</u>	
3. NAME OF DECEASED (Type or print) <u>Rosemary A. Mays</u>		4. DATE OF DEATH <u>Dec. 7</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 23, 1942</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (State or foreign country) <u>Parkton Md. R.D.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Albert L. Mays</u>	
14. MOTHER'S MAIDEN NAME <u>Melvia Bull</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Albert L. Mays</u> Address <u>Hampstead Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the skull</u> <u>819x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck a bridge abutment.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10.30 a.m. Dec. 7 19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Beckleysville, Balto., Md.</u> (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>A. M. France</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hampstead Md. R.D.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hartenstein</u>		24a. REC'D BY REGISTRAR <u>DEC 14 59</u>	
ADDRESS <u>New Freedom Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13442
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ISACTIONOR</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN TB <u>20 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE STATE HOSP.</u>		e. STREET ADDRESS <u>REF #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD</u> <u>MCGOWAN</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER</u> <u>15</u> <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1900</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES MCGOWAN</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA HONN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>UNK.</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>S.G.S.H. RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>SUDDEN CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PROBABILE CORONARY OCCLUSION</u> DUE TO (c) <u>DEATH Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CENTRAL NERVOUS SYSTEM SYPHILLIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>57</u> , to <u>12/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Anthony S. Sampson</u> M.D.		<u>PRINCE GEORGE STATE HOSP.</u> <u>12/15/57</u>	
PHYSICIAN'S NAME (Type) <u>ANTHONY S. SAMPSON</u>		<u>CATONSVILLE</u> <u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-20-60</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Univ. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

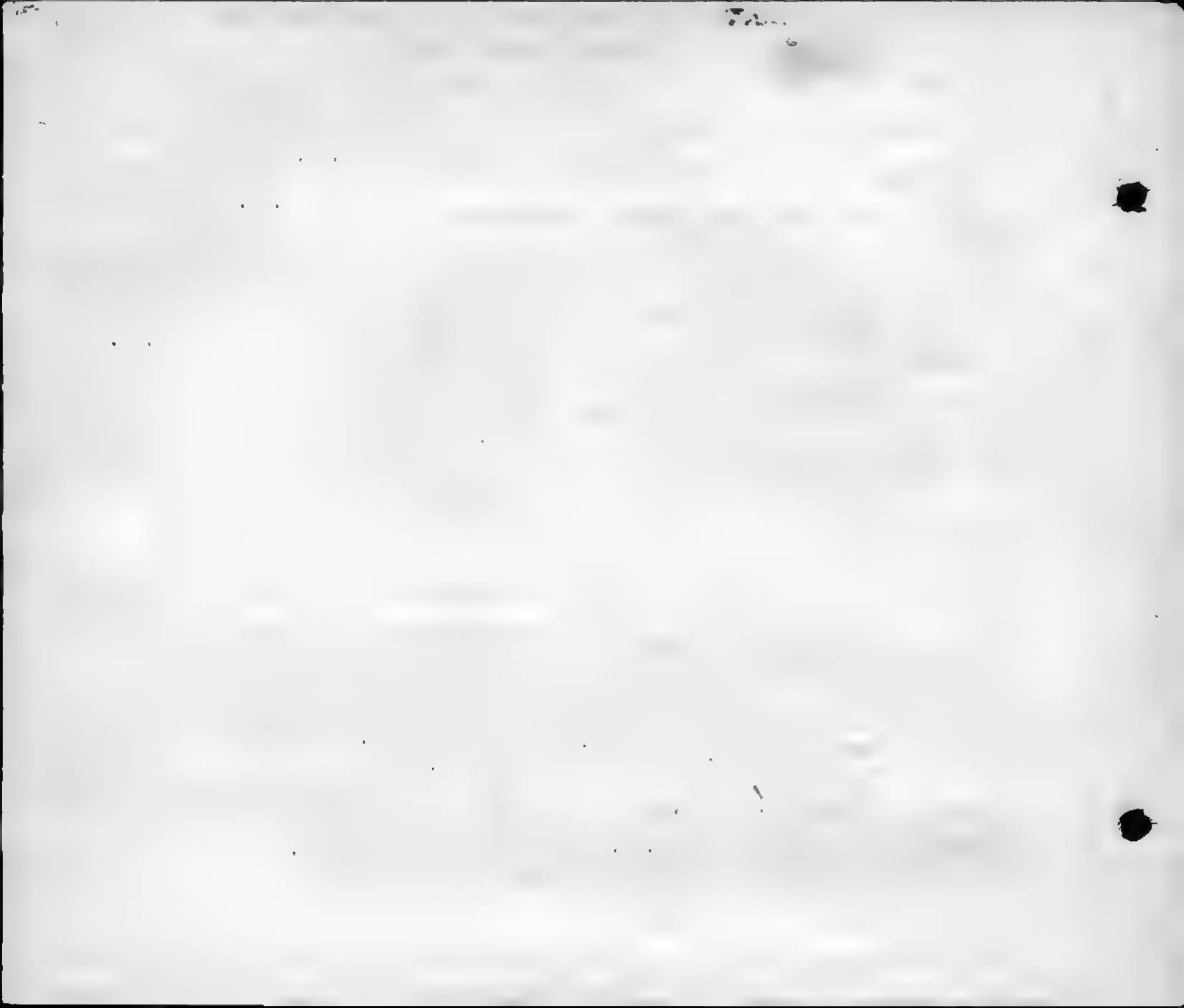
13419

13442

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6yrlmth23dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1006 S. Caroline - S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Sipe Last McKnight				4. DATE OF DEATH Month December Day 21 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cargo packer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George McKnight				14. MOTHER'S MAIDEN NAME Mary ? Sipe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown Nd		16. SOCIAL SECURITY NO 578-30-7664		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Adenocarcinoma of the sigmoid. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 24 , 19 59 to Dec. 21 , 19 59 , that I last saw the deceased alive on Dec. 21 , 19 59 , and that death occurred at 10:55a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		M D SPRING GROVE STATE HOSPITAL		ADDRESS (Street, city or town, state) Catonsville 28, Md.		DATE SIGNED 12-21-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-23-59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co Inc		ADDRESS 517-11th St SE Washington D.C.		24a. REC'D BY REGISTRAR DEC 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13443

CERTIFICATE OF DEATH

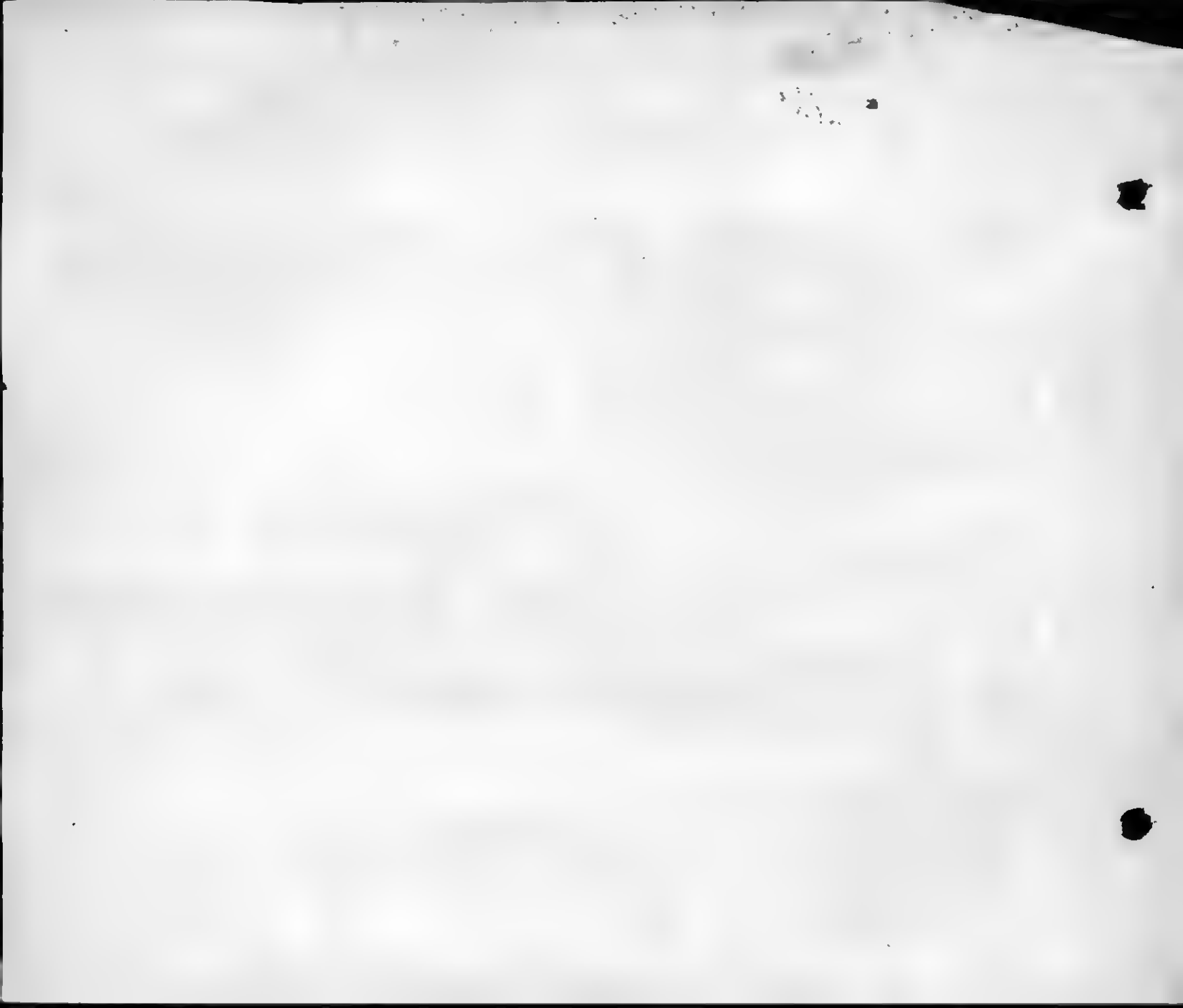
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN IB 5 YEARS + 9 MO.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 105 UPNOR RD		
3. NAME OF DECEASED (Type or print) First IRENE Middle E Last METTEE		4. DATE OF DEATH Month DEC Day 25 Year 1959		
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-1876	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME THOMAS GIFFORD		14. MOTHER'S MAIDEN NAME IRENE STEVENS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE		
17. INFORMANT Frank L. Smith		Address Cockeysville, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Vascular Disease cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 4 years.	
21. I certify that I attended the deceased from 4-27 , 1954, to 12-23 , 1959, that I last saw the deceased alive on 12-23 , 1959, and that death occurred at 6:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/25/59			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE William J. Cook		M.D. Cockeysville, Md		
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-28-59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13444

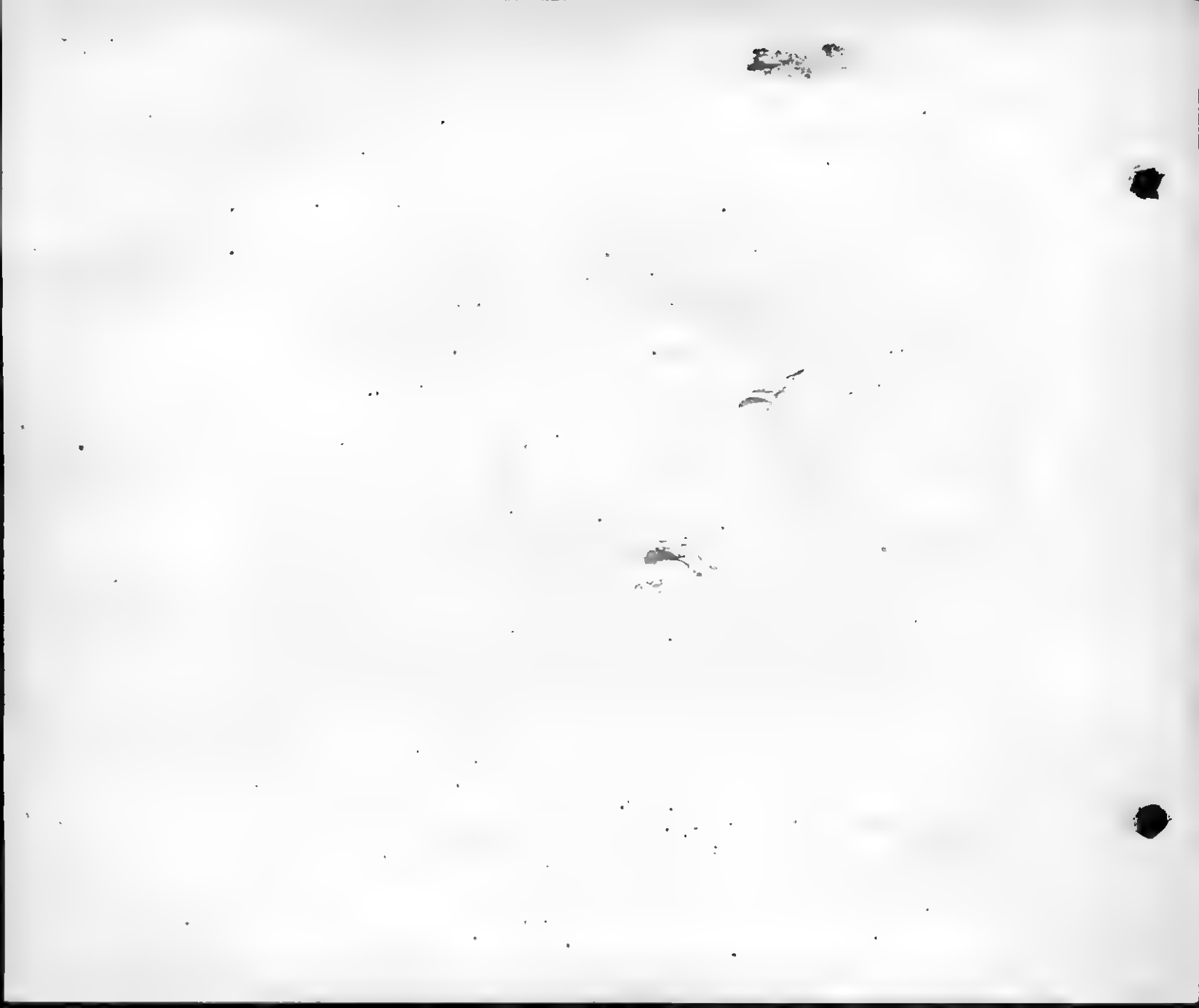
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 Pleasant Hill Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERBERT Middle C. Last MILES				4. DATE OF DEATH Month Dec. Day 1 Year 1959			
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1899		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Miles				14. MOTHER'S MAIDEN NAME Carrie Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO -		INFORMANT Mrs. Blanche Miles - 126 Pleasant Hill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis DUE TO Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency							INTERVAL BETWEEN ONSET AND DEATH 15 minute 5 yrs 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1- 19 40 to 12-1- 19 59 , that I last saw the deceased alive on 10-5- 19 59 , and that death occurred at 10-30- M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 12-1-59 ACTUAL SIGNATURE James G. Saffell M.D. Reisterstown Md PHYSICIAN'S NAME (Type) James G. Saffell M.D. - Reisterstown Md							
22a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balto. 17				24a. REC'D BY REGISTRAR DATE DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13422

13443

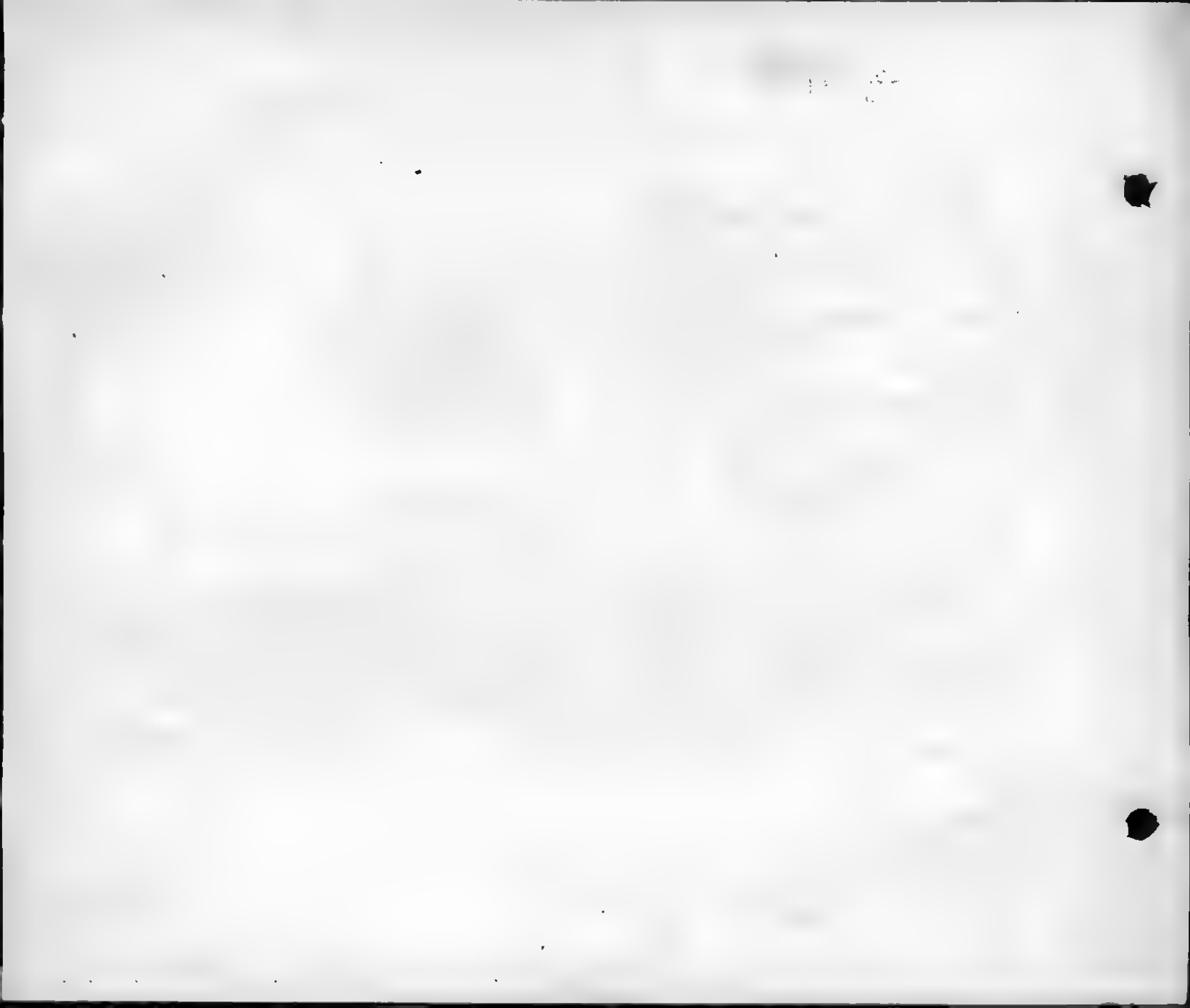
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>T</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6826 Navajo Drive</u>		e. STREET ADDRESS <u>6826 Navajo Drive</u>	
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> <u>MILLER</u>		4. DATE OF DEATH <u>12-9-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel</u>		14. MOTHER'S MAIDEN NAME <u>Minnie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>Stanley Miller</u>	
17. INFORMANT <u>Stanley Miller</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175.0</u> <u>Cerebral metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma, ovary?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastases to lung & pleura</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/26</u> , 19 <u>59</u> , to <u>12-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>59</u> , and that death occurred at <u>12-10</u> , 19 <u>59</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley R. Stembach</u> M.D.		ADDRESS (Street, city or town, state) <u>3334 Dorfield Ave</u>	
PHYSICIAN'S NAME (Type) <u>Stanley R. Stembach</u>		DATE SIGNED <u>12/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Witz & Chaim</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Evers Inc</u> ADDRESS <u>2100 Euterio Place</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

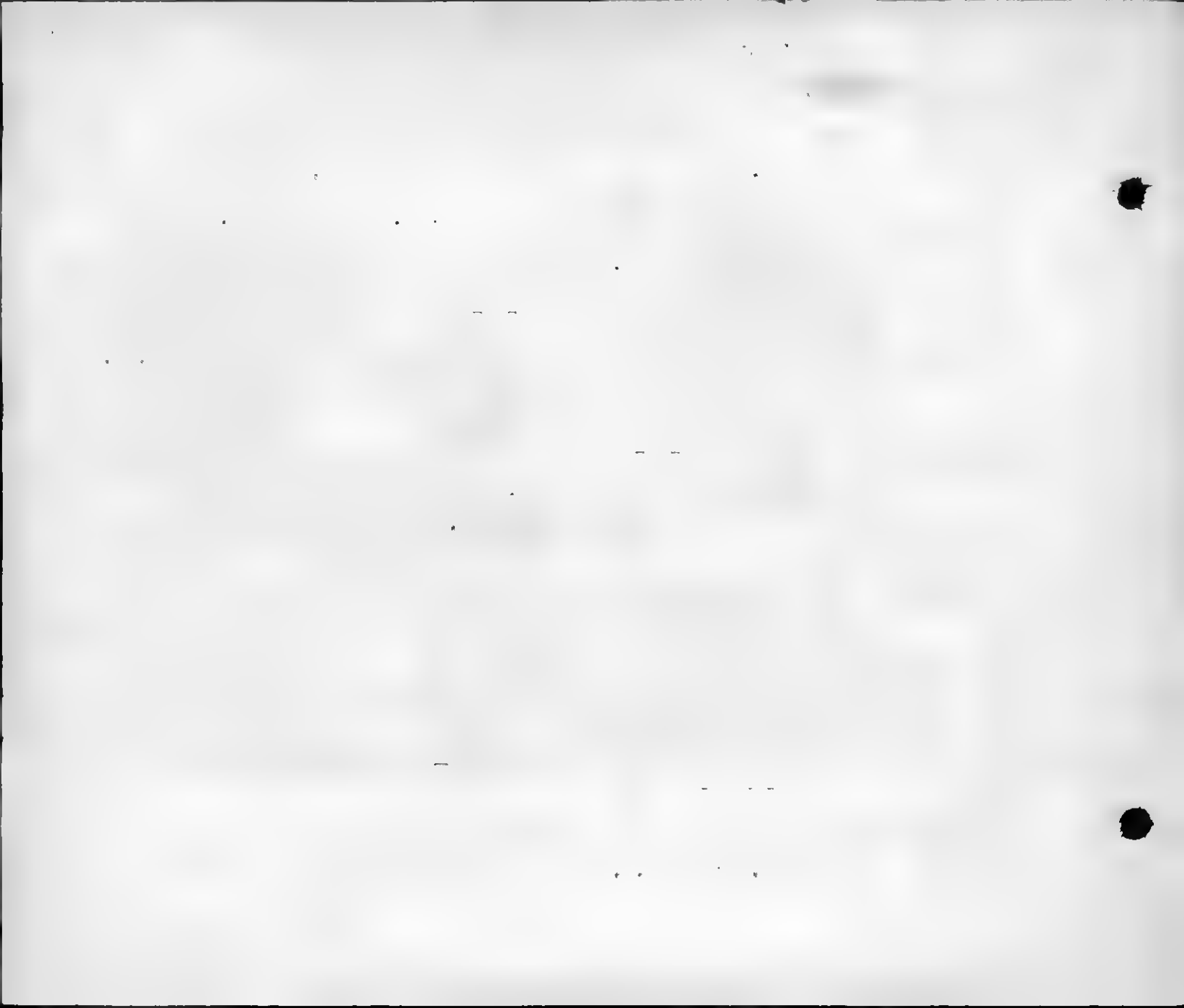
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13423**

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH 13446 a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point, 19, Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 5, d. STREET ADDRESS 812 N. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John W. Miller		4. DATE OF DEATH 12 21 1959		5. SEX M 6. COLOR OR RACE Negro			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-1931		9. AGE (in years last birthday) 28 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer Helper			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME John Miller			
14. MOTHER'S MAIDEN NAME Lottie Rose		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 226-32-7273			
17. INFORMANT Mrs. Rosa May Miller		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Myocardial Infarction Coronary Thrombosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Spec. 1) Removal		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery			
22d. LOCATION (City, town, or county) Nutbush, Virginia		22e. REC'D BY REGISTRAR DEC 28 '59		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick 1412 E. Preston St.							



13447

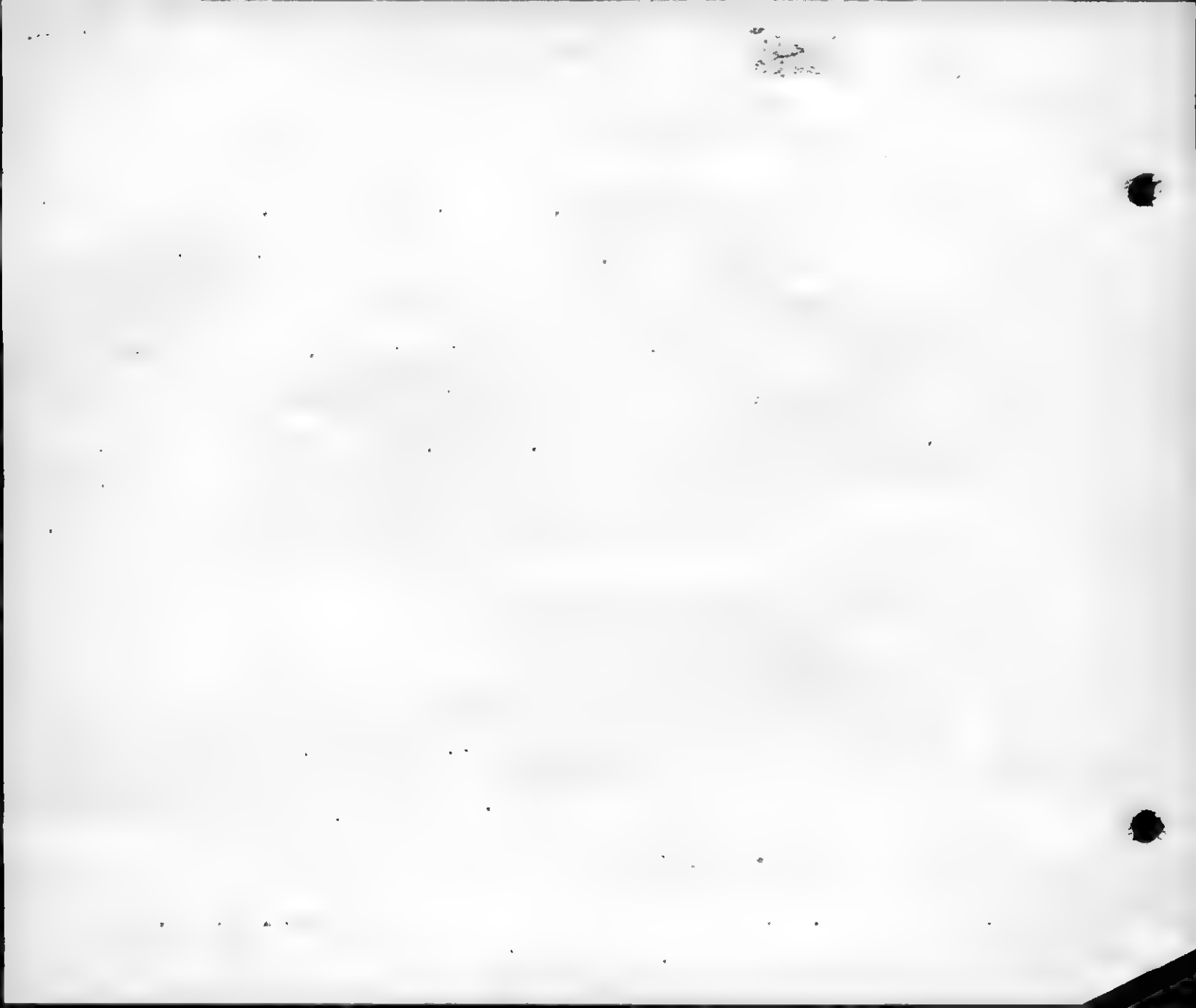
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fullerton Nursing Home 8409 Belair Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 11 Cliftwood Rd.	
3. NAME OF DECEASED (Type or print) First Selvia Middle C. Last Miller				4. DATE OF DEATH Month December Day 8 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1878		9. AGE (In years last birthday) yrs 81	10. IF UNDER 1 YEAR Months 8 Days 8 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Scott				14. MOTHER'S MAIDEN NAME Nancy Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. James E. Miller		Address 4206 Parkside Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROSIS, GENERALIZED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 YEARS 20 YEARS							INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 20 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 18, 1958 to DECEMBER 5, 1959 , that I last saw the deceased alive on DEC. 5, 1959 , and that death occurred at L.A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. G. Lewis				ADDRESS (Street, city or town, state) 6232 BELAIR RD. BALTIMORE, MD.			
PHYSICIAN'S NAME (Type) H. G. SWISS				DATE SIGNED DEC. 9, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DEC 11 1959	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

13425

13448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls Balto. Co.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Scushine Ave</u>		d. STREET ADDRESS <u>Scushine Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>B. Monmonier</u> Last <u>Monmonier</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S A</u>	
13. FATHER'S NAME <u>Charles G. Monmonier</u>		14. MOTHER'S MAIDEN NAME <u>Annie Armstrong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Rev Charles B. Monmonier</u>		Address <u>1410 Riverside Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Chronic endocarditis myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 yr. +</u> <u>7 yr +</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Parotitis - St. cerebral thrombosis H. facialis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1953</u> to <u>Dec 18, 1953</u> that I last saw the deceased alive on <u>Dec. 18, 1953</u> and that death occurred at <u>9:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isabel H. McClinton M.D.</u>		ADDRESS (Street, city or town, state) <u>Bel Air Rd, Kingsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Isabel H. McClinton, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Dec 22-53</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Falls Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Kuppel Bur.</u>		ADDRESS <u>7110 Belair Rd. 6</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '53</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF RESIDENT OF HEALTH—BALTIMORE, 18

Item 2 Fil C254 1-11-60 et

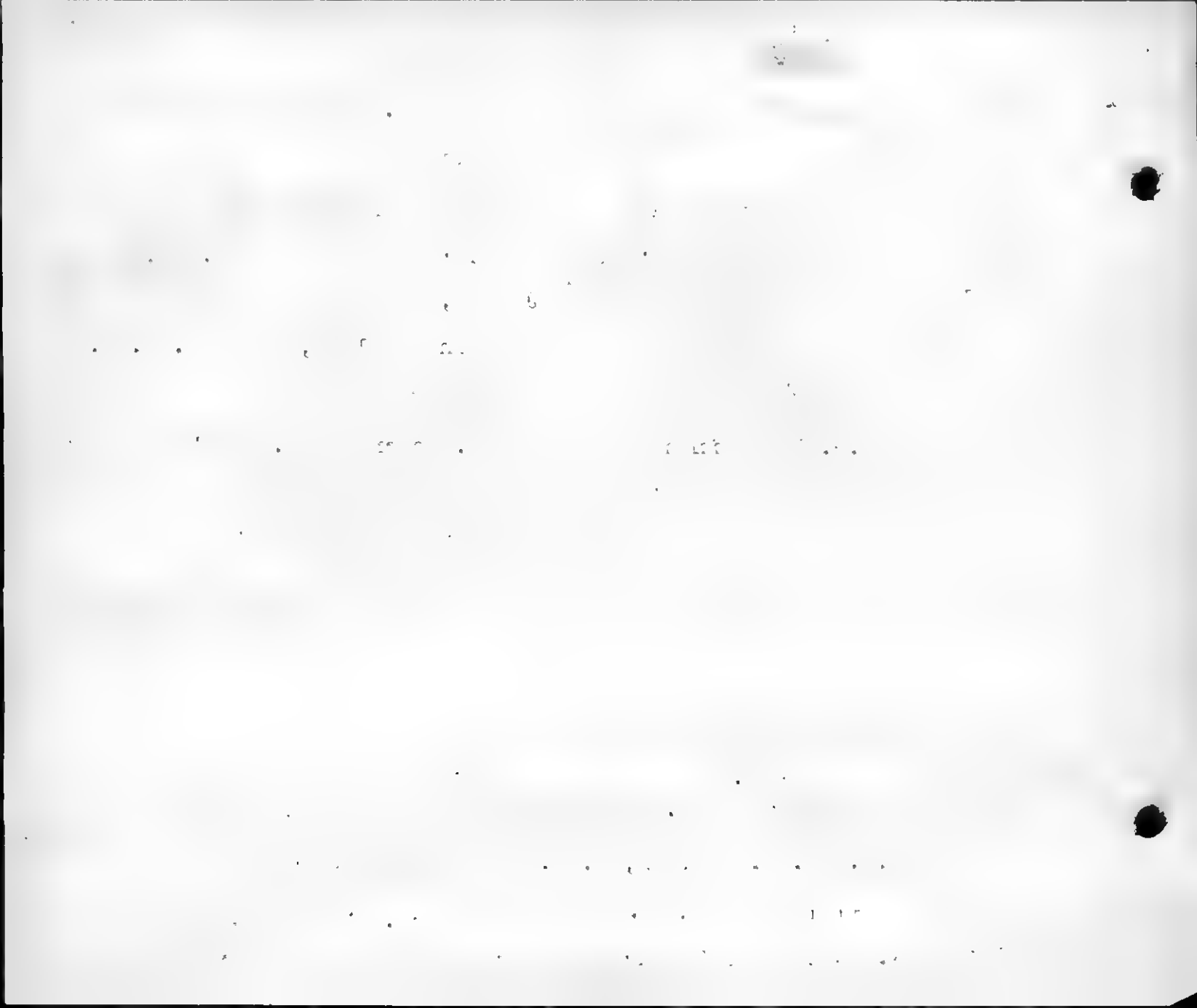
13449

CERTIFICATE OF DEATH

13426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore A.A.Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore/ Greenland Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Eugene Last Mounts				4. DATE OF DEATH Month Dec. Day 31 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1887	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		11. AGE (In years last birthday) 72 yrs.		12. IF UNDER 24 HRS Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Council Bluff, Iowa		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. none			
17. INFORMANT Edgar C. Powers				Address 9 E. Franklin Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Multiple Cerebral/Vascular Accidents DUE TO (b). Generalized Arteriosclerosis DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 12/30/59 p. m. 12/31/59 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 12/30/59 to 12/31/59 , that I last saw the deceased alive on 12/30/59 and that death occurred 8:35 A.M. from the causes and on the date stated above ACTUAL SIGNATURE W. E. McGrath M.D. 1303 Frederick Rd (28) DATE SIGNED 1/2/60 PHYSICIAN'S NAME (Type) EXE. W. E. McGrath, M. D. 1303 Frederick Road 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/4/60 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue 24a. REC'D BY REGISTRAR JAN 4 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kneass							



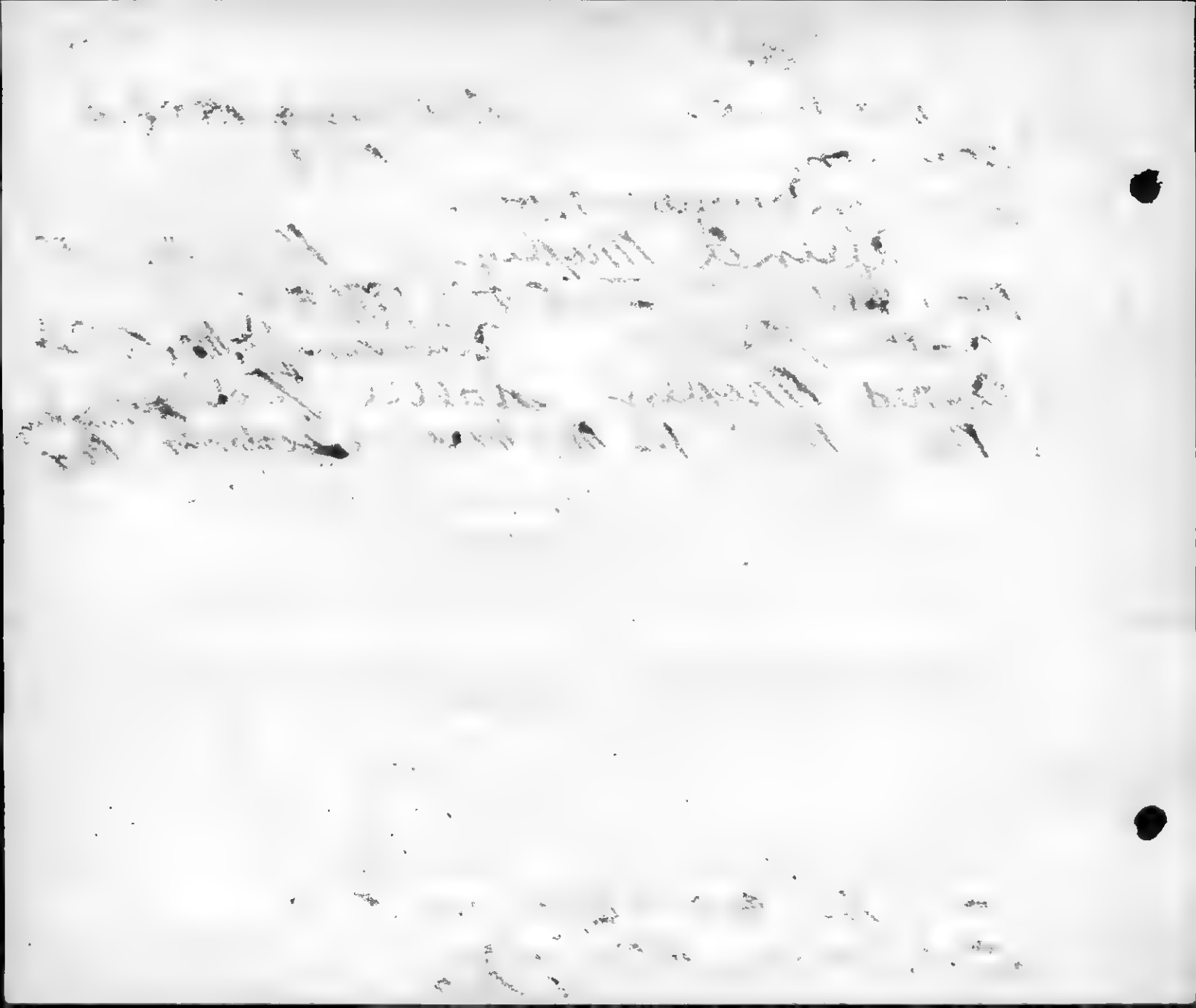
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <u>Marlinton</u> COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write street and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Allen S. Moxley</u> First <u>Allen</u> Middle <u>S.</u> Last <u>Moxley</u>		4. DATE OF DEATH <u>Dec. 2, 1959</u> Month <u>Dec.</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u> COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1871</u> yrs <u>88</u>	9. AGE (In years, months, days, hours, minutes) <u>88</u> yrs <u>0</u> mos <u>0</u> days <u>0</u> hrs <u>0</u> min
10a. USUAL OCCUPATION (Give kind of work, even if retired) <u>Cattle Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allegany Co., W. Va.</u>	
13. FATHER'S NAME <u>Alfred Moxley</u>		14. MOTHER'S MAIDEN NAME <u>Ballie Polimer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Mrs. Maxine Goodman</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Decompensative Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 10, 1958</u> to <u>Dec. 2, 1959</u> that I last saw the deceased alive on <u>Dec. 2, 1959</u> and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.		ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md.</u>	
PRINT NAME (Type) <u>LAURENCE C. POST</u>		DATE SIGNED <u>12/2/59</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <u>Dec. 7, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wytheville</u>	22d. LOCATION (City, town or county) (State) <u>Ta.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Marlinton Md</u>		24a. READ BY REGISTRAR DATE <u>DEC 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md b. COUNTY 12-04	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles S Napiraski		4. DATE OF DEATH 12/24/59 19	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gardner ret		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 66 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anton Napiraski		14. MOTHER'S MAIDEN NAME Constance Dardes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW L		16. SOCIAL SECURITY NO. 212 32 2459 A	
17. INFORMANT Mrs Frances Armstrong		Address 6540 Parnell Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO A-S-C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) No	
20c. TIME OF INJURY Hour 19 a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/28/59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) German Hill Road
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		24b. REGISTRAR'S SIGNATURE Arthur L. Kneap	
ADDRESS 2112 Dundalk Ave		DATE DEC 30 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

13451

13451

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film 6254 12-30-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

13429
32

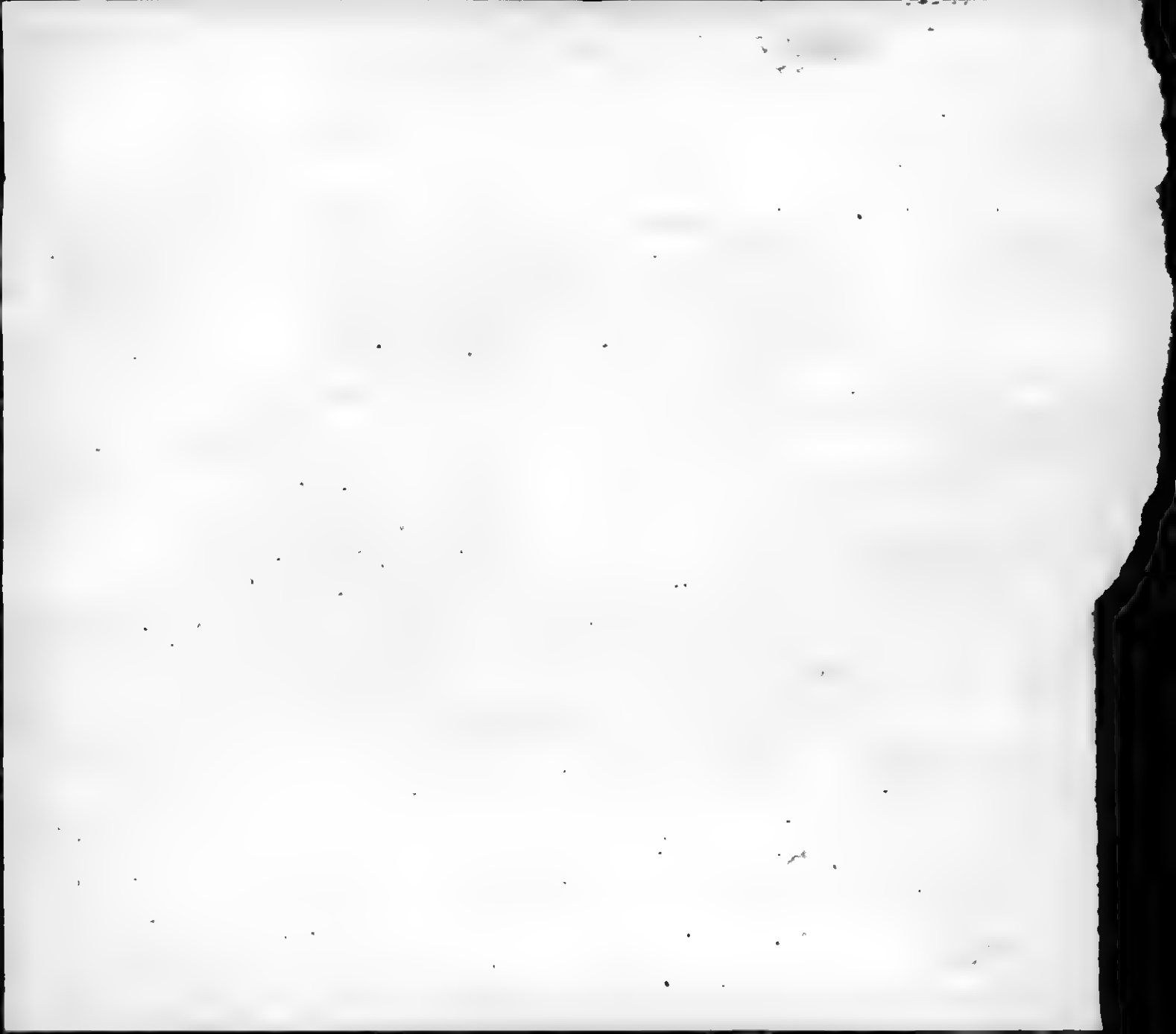
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EDLAND FARM WOODSTOCK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS EDLAND FARM 10x2	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH JULIUS OLSZEWSKI		4. DATE OF DEATH Month Day Year 12 - 17 - 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Unknown DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1900
9. AGE (In years last birthday) yrs. 59		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? 2-1 ✓	
13. FATHER'S NAME NICHOLAS OLSZEWSKI		14. MOTHER'S MAIDEN NAME ELVANINA 2	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-6859	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ONE MONTH DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7-1959 to 12-17-1959 , that I last saw the deceased alive on 12-16-1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-22-59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
St. Peter		Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Newell, Pikes &		24a. REC'D BY REGISTRAR DATE DEC 23 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ^{or} page 3 should be detached for use as the burial-transit permit.
the registrar prior to burial, cremation, or removal, and

MEDICAL CERTIFICATION

attending physician and completely filled in by the funeral director,
Tilen please remove carbon papers. Pages 1 and 2 should be filled with
any event within 72 hours after death.



13453

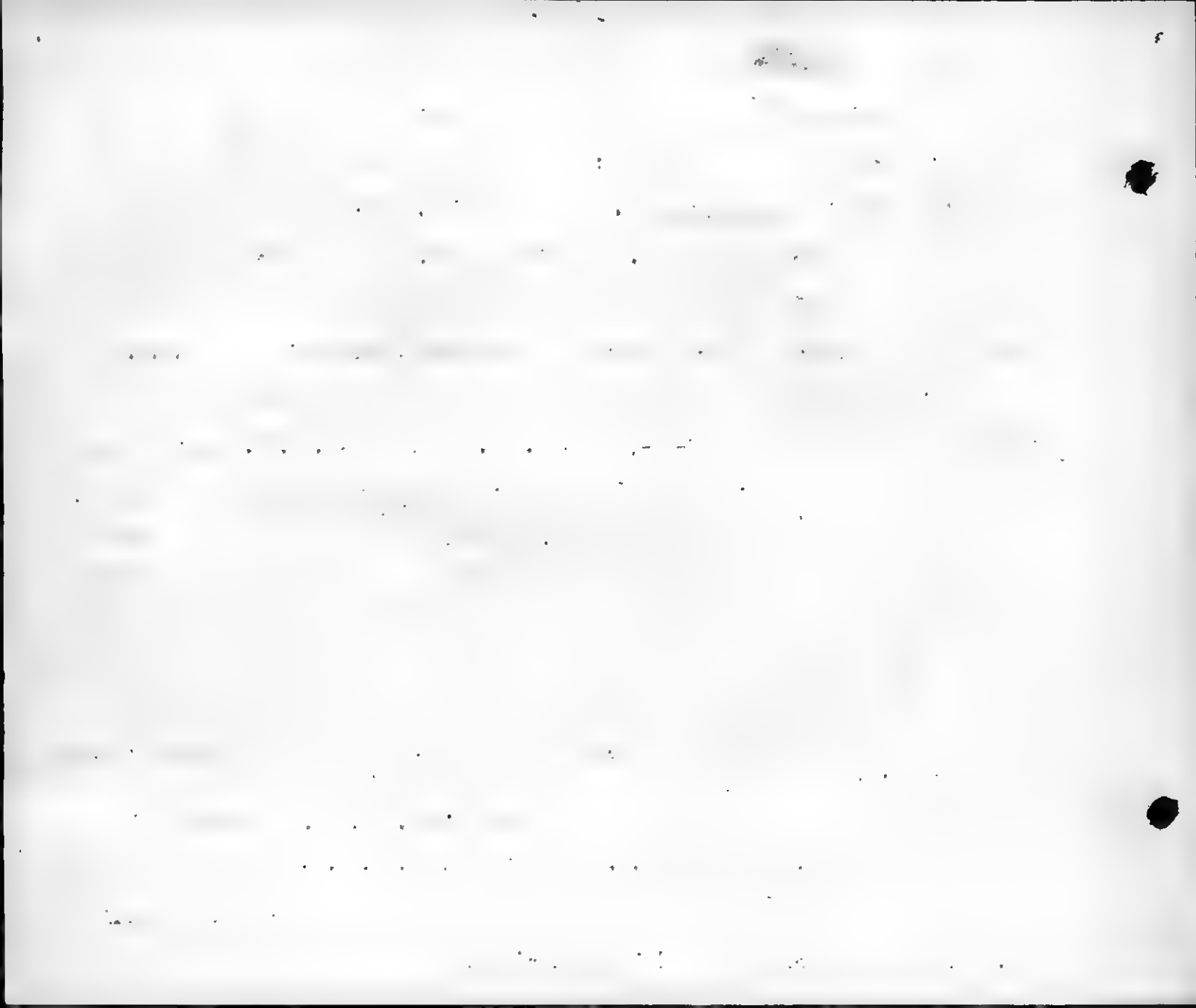
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 64 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 1135 S. Manover Street							
3. NAME OF DECEASED (Type or print) First HENRY Middle J. Last PAAR SR.				4. DATE OF DEATH Month DECEMBER Day 25 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/97	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Operator		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand Paar				14. MOTHER'S MAIDEN NAME Emma Leifert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		INFORMANT Clin. Rec. VA Hosp, Balto. Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS TO HILAR LYMPH NODES AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL ARTERIOSCLEROSIS (c) OLD MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 22, 1959 to December 25, 1959 , and that death occurred at 10:15 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		ADDRESS (Street, city or town, state) VAH, BALTO. MD. FT. HOWARD DIVISION					
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		DATE VAH, BALTO. MD. FT. HOWARD DIVISION 12/25/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE A. Howard Evans Funeral Home, Baltimore, Maryland				24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



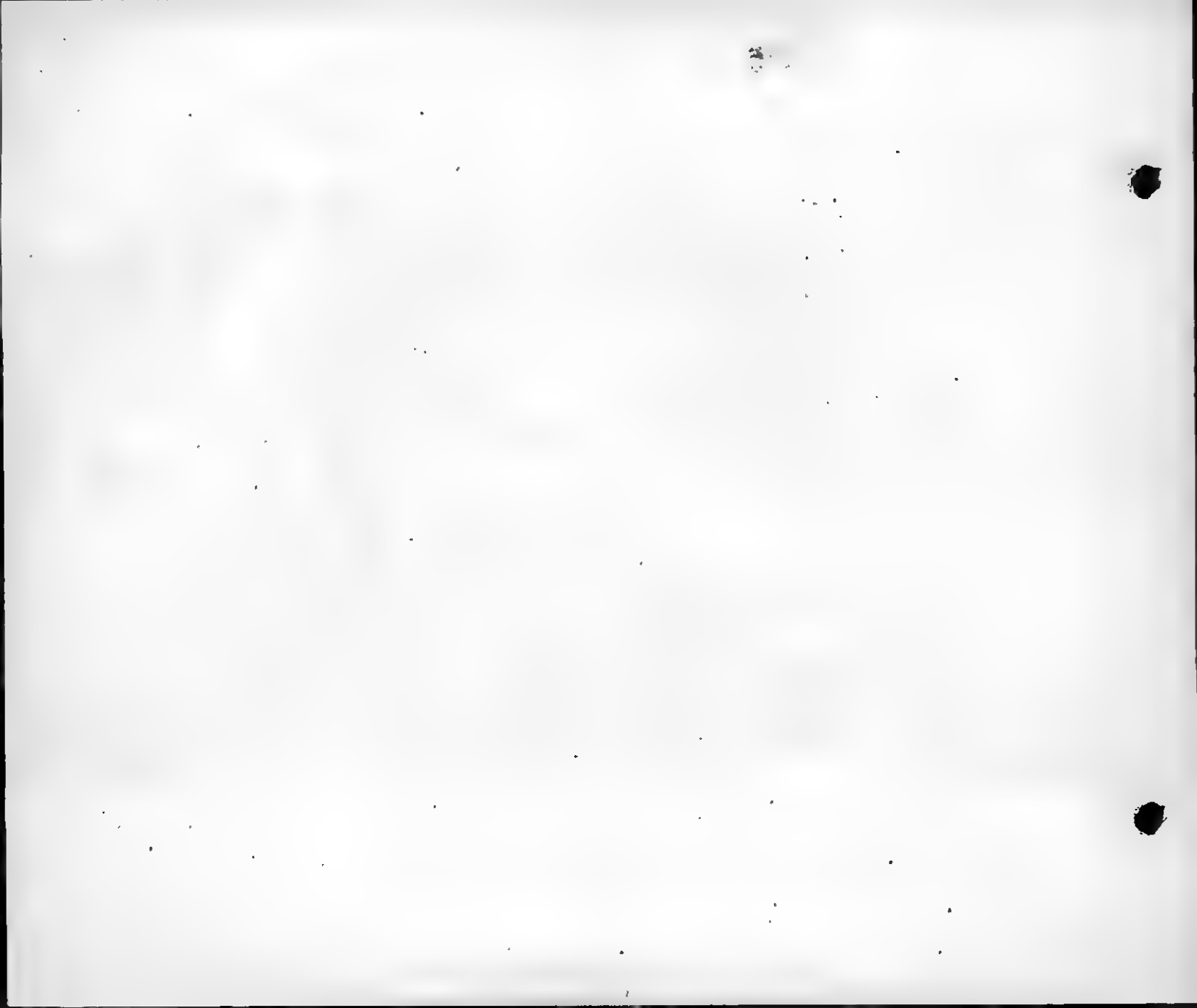
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13454

CERTIFICATE OF DEATH

Reg. Dist. No. 13432

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY WYCOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS, MD		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TR. SCHOOL		d. STREET ADDRESS 407 CLAYBOURNE ST.	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE DOREEN PALMER		4. DATE OF DEATH Month Day Year 12 27 1959	
5 SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1959
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months Days Hours Min 9 7 - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KENNETH PALMER		14. MOTHER'S MAIDEN NAME ZELLINE CROCKETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO —	
17. INFORMANT ROSEWOOD RECORDS		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia, acute 470X DUE TO and chronic with bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) otitis media DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/23 , 19 59 to 12/27 , 19 59 that I last saw the deceased alive on 12/27 , 19 59 , and that death occurred at 11:20 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore 14, Md.	
DATE SIGNED 12-27-59			
PHYSICIAN'S NAME (Type) Peter W Rieckert			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/30/59	22c. NAME OF CEMETERY OR CREMATORY quantico	22d. LOCATION (City, town, or county) (State) quantico Md.
23. FUNERAL DIRECTOR'S SIGNATURE Clinton O. Stewart		24a. REC'D BY REGISTRAR JAN 4 '60	
ADDRESS Salisbury Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

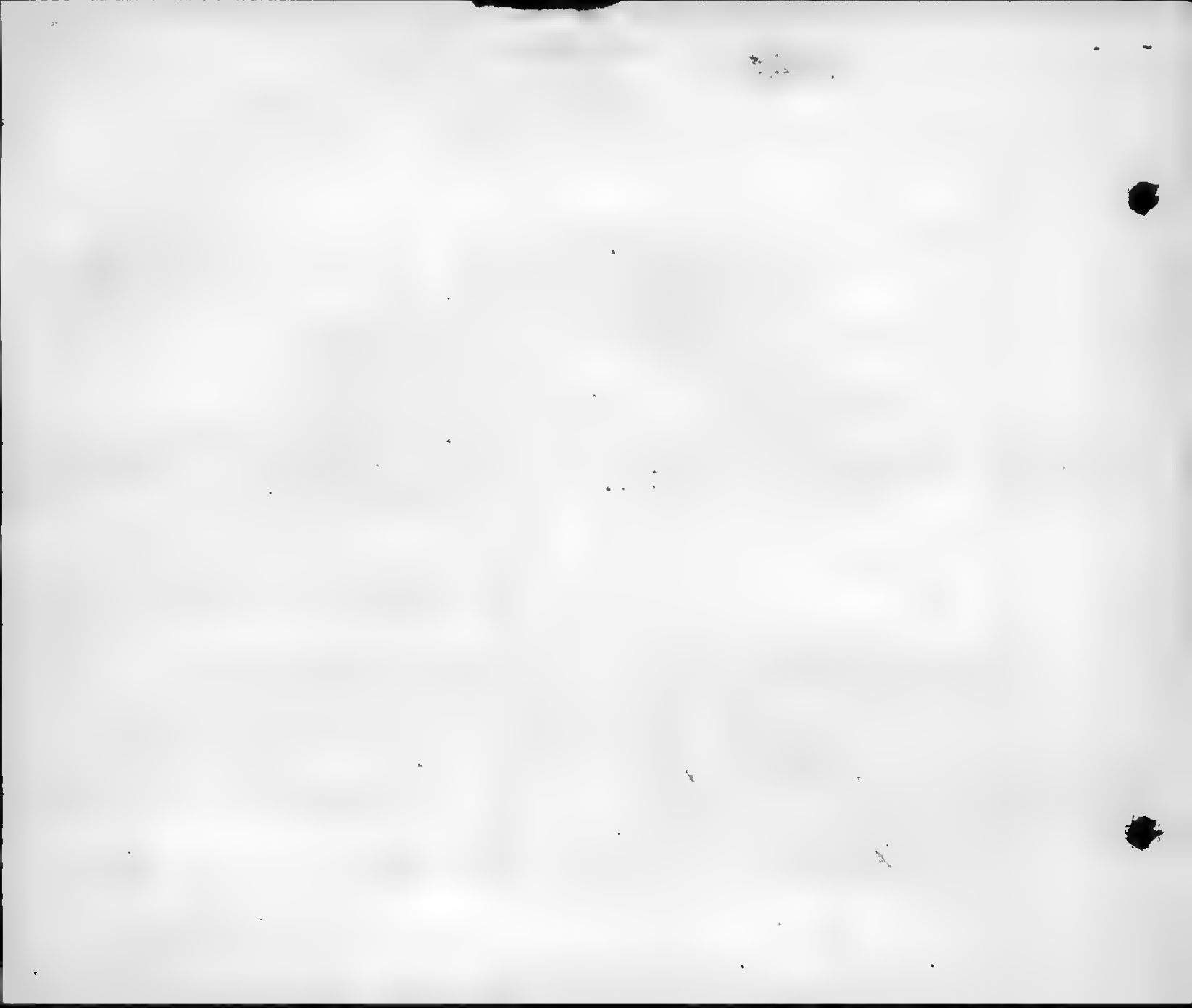
13433

13455

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>316 Murdock Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>K.</i> Last <i>Parlett</i>				4. DATE OF DEATH Month <i>December</i> Day <i>26</i> Year <i>1959</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 2, 1879</i>		9. AGE (In years (Day birthday) yrs. <i>80</i>)	IF UNDER 1 YEAR Months <i>19</i> Days <i>19</i>	IF UNDER 24 HRS Hours <i>19</i> Min <i>19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore County</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Maddox</i>				14. MOTHER'S MAIDEN NAME <i>Frances Hughes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Mrs Ruth E. Neisser 316 Murdock Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Descending Colon</i> <i>155.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>June 5, 1954</i> to <i>Dec. 26, 1959</i> , that I last saw the deceased alive on <i>Dec. 26, 1959</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Laurence C. Post</i>		M.D. <i>6805 York Rd.</i>		ADDRESS (Street, city or town, state) <i>Baltimore 12</i>		DATE SIGNED <i>12/29/59</i>	
PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 30, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John A. Moran 3000 E. Baltimore Street</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 31 59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be relayed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13456

CERTIFICATE OF DEATH

13434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyromthllyds	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1414 West Baltimore St.	
3. NAME OF DECEASED (Type or print) First Mamie Middle Parsons Last Parsons		4. DATE OF DEATH Month Dec. Day 23 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease long standing DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22, 1959 to Dec. 23, 1959 , that I last saw the deceased alive on Dec. 23, 1959 , and that death occurred at 7:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		DATE SIGNED 12/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Lacey, Inc.		ADDRESS Balto. 30 Md.	
24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL DEPARTMENT OF HEALTH: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13457

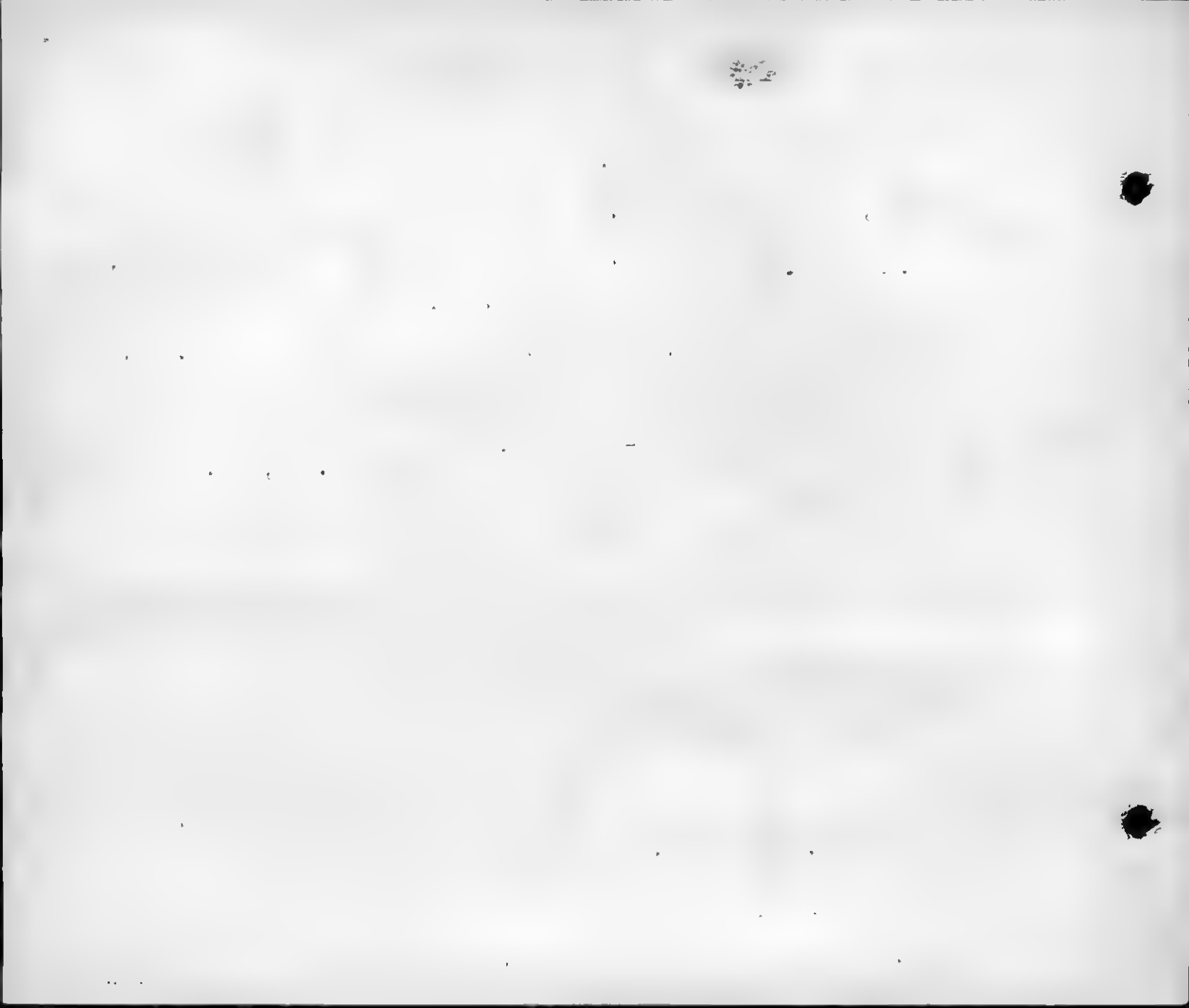
CERTIFICATE OF DEATH

13435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek		c. LENGTH OF STAY IN 1b 6 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence, 7347 Waldman Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek	
f. STREET ADDRESS 7347 Waldman Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle E. Last Patterson		4. DATE OF DEATH Month December Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1907
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 5 Days 12 Hours 15 Min 00	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Patterson		14. MOTHER'S MAIDEN NAME Mary Pennington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army WWII		16. SOCIAL SECURITY NO 236-07-7254	
17. INFORMANT Mrs. Etta (Elizabeth) Patterson		Address 7347 Waldman Ave. 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X		INTERVAL BETWEEN ONSET AND DEATH 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1954 to Dec 23, 1959 , that I last saw the deceased alive on Dec 23, 1959 , and that death occurred at 10:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon E. Kassel		DATE SIGNED 3501 St Paul Street Balt Md 12/24/59	
PHYSICIAN'S NAME (Type) Leon E. Kassel, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Athens Cemetery		22d. LOCATION (City, town, or county) (State) Athens, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

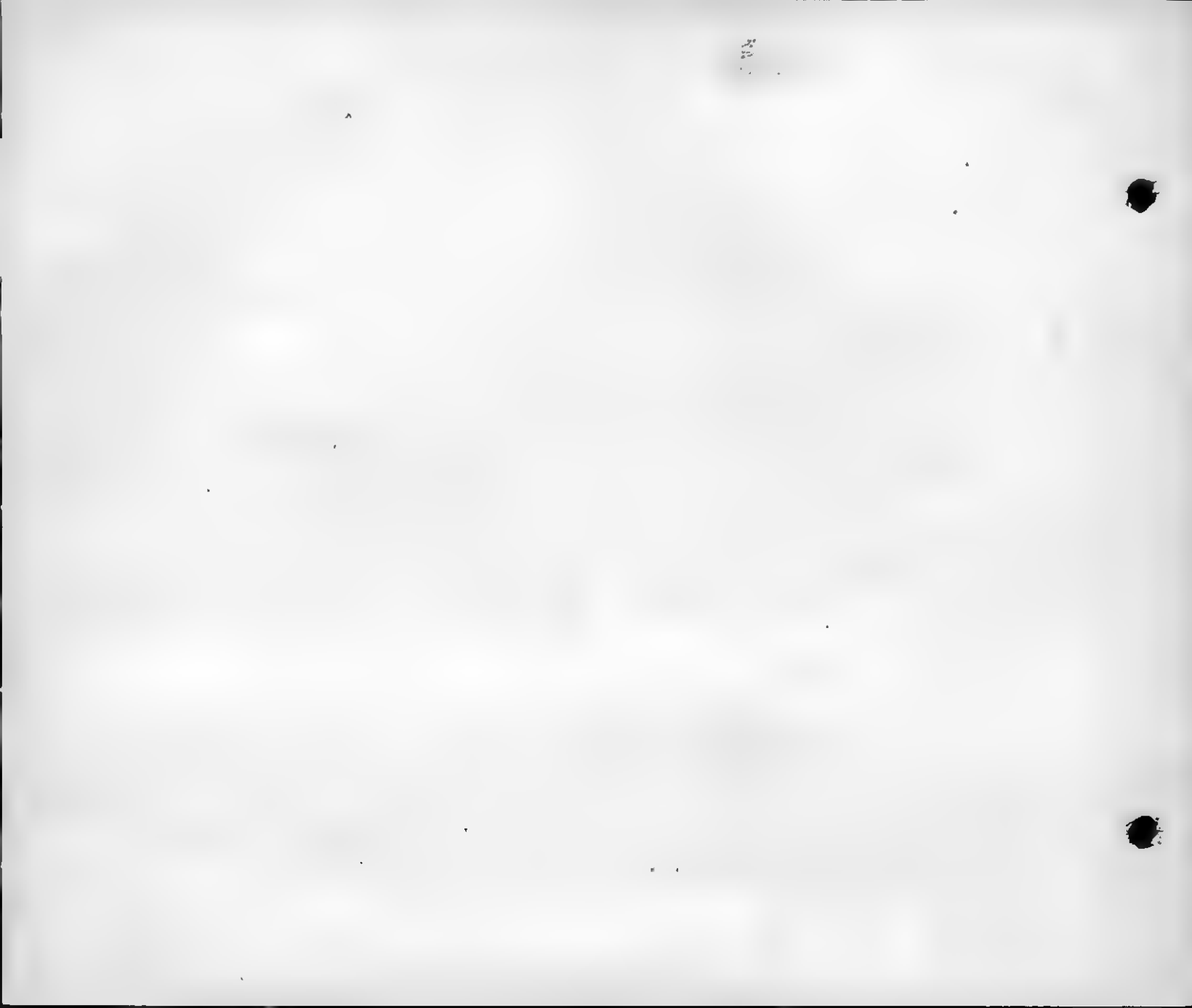
Reg. Dist. No. 32

13458

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 2928 BOARMAN AVE	
3. NAME OF DECEASED (Type or print) First MELCHOR Middle WINFIELD Last PEREGOY		4. DATE OF DEATH Month 12 Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTORMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STOPHEL PEREGOY		14. MOTHER'S MAIDEN NAME SARAH BULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-0912	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, BLADDER NECK CONTRACTURE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-28 , 19 59 to 12-18 , 19 59 , that I last saw the deceased alive on 12-18 , 19 59 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE _____ M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-59	
22c. NAME OF CEMETERY OR CREMATORY Foreston Cemetery, Foreston, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		24a. REC'D BY REGISTRAR DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13459

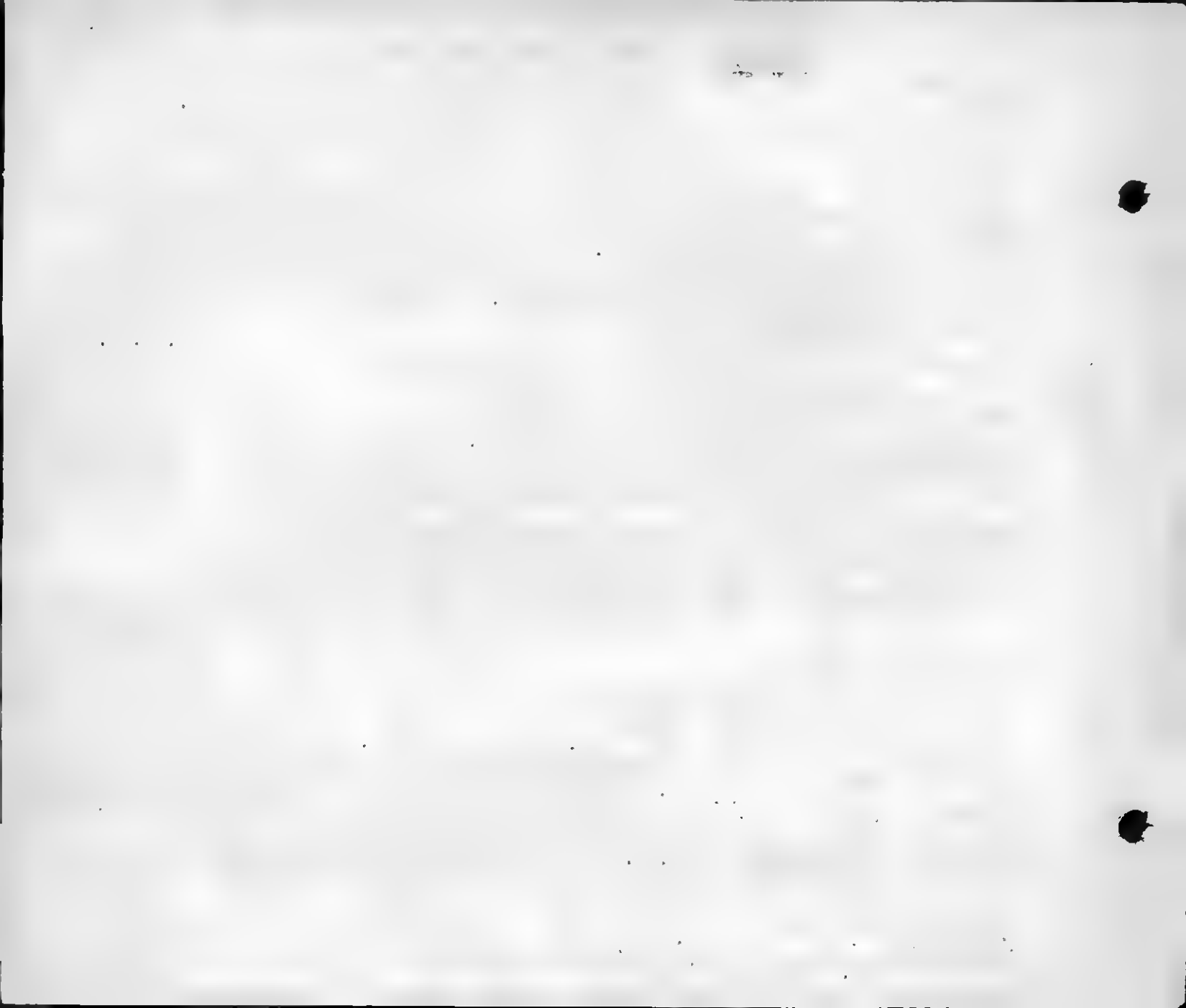
CERTIFICATE OF DEATH

Reg. Dist. No.

13457

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yrlmth22dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California, Maryland 18-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle N. Last Perry				4. DATE OF DEATH Month December Day 15 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1897?	9. AGE (In years last birthday) 62? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James				14. MOTHER'S MAIDEN NAME Ellen Prestly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk own		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary and generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 13, 1959 , to Dec. 15, 1959 , that I last saw the deceased alive on Dec. 15, 1959 , and that death occurred at 7:00p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-16-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-59		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Great Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. L. M. Hallingby				ADDRESS Lernantown, Md.		24a. REC'D BY REGISTRAR DATE DEC 18 '59	
				24b. REGISTRAR'S SIGNATURE Robert S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13460

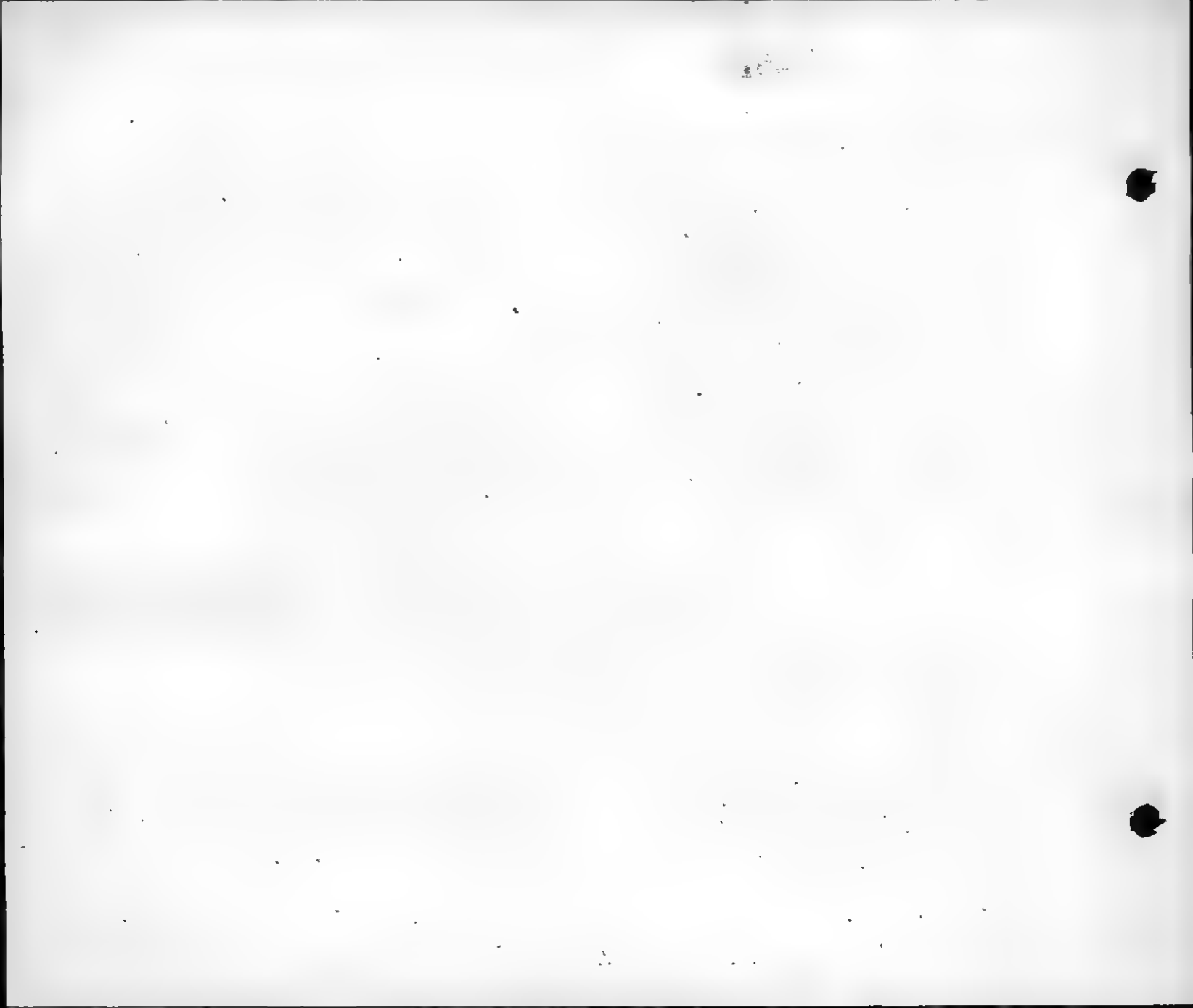
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebbrville, Md.</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3106 Cresson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert Pezzica</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hilgarner Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 165X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-12</u> , 19 <u>58</u> , to <u>12-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Stanley Cohen</u> M.D.		ADDRESS (Street, city or town, state) <u>7306 Ed. by Old Balto</u> DATE SIGNED <u>12/29/59</u>	
PHYSICIAN'S NAME (Type) <u>B. STANLEY COHEN, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gowanson</u> ADDRESS <u>101 Hollins</u>		24a. REC'D BY REGISTRAR <u>DATE DEC 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO HOSPITAL CONSULTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

VS A15 (4)
15M 9/58



13461

CERTIFICATE OF DEATH

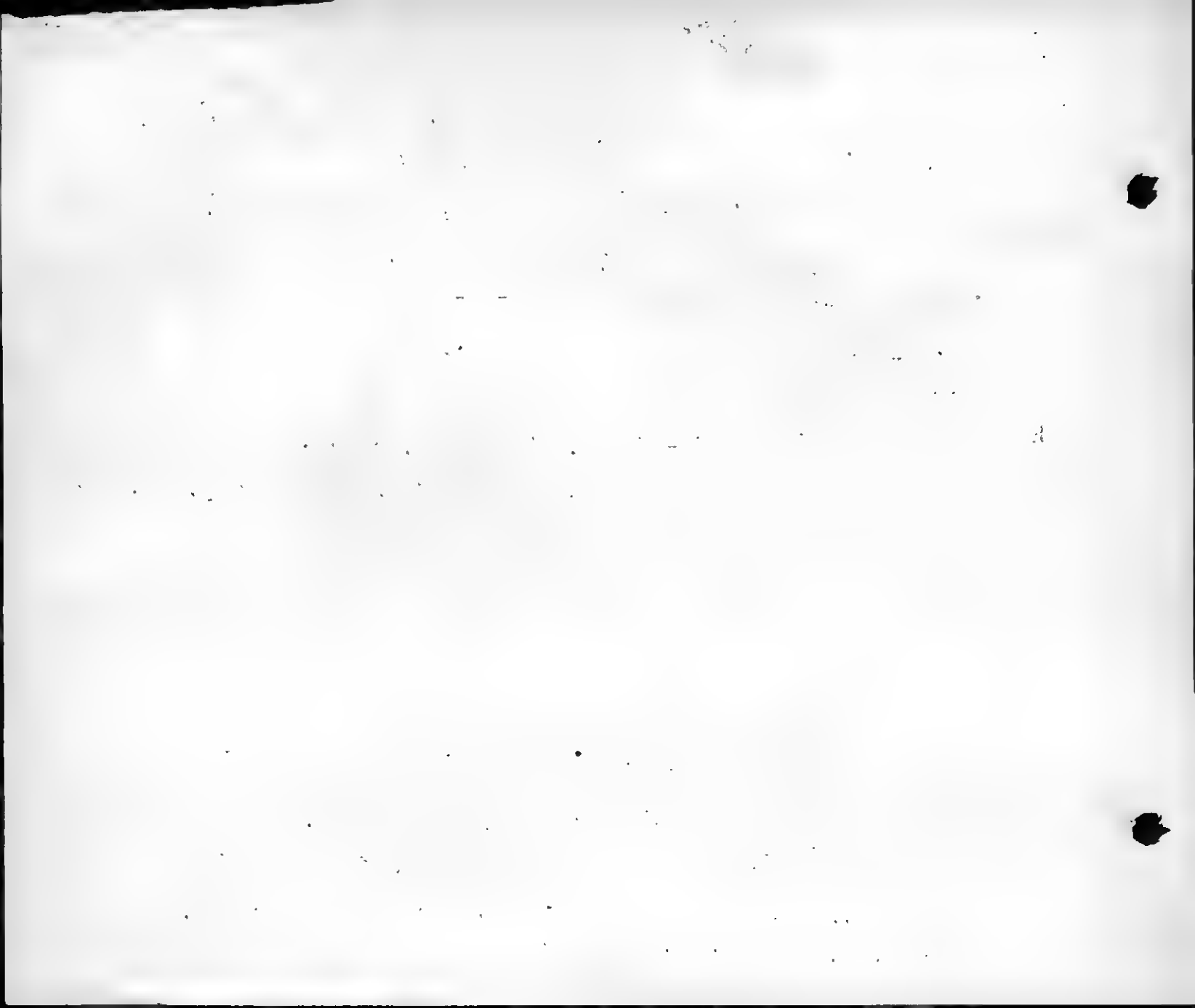
Reg. Dist. No. 13439

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8004 Old Harford Rd</u>				d. STREET ADDRESS <u>8004 Old Harford Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>N.</u> Last <u>Pierce Sr.</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1959</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1917</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>steel worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		
13. FATHER'S NAME <u>Herbert Pierce</u>			14. MOTHER'S MAIDEN NAME <u>Edith Kirby</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>WW 2</u>			16. SOCIAL SECURITY NO. <u>213-05-8812</u>		INFORMANT <u>Alberta F. Pierce</u> Address <u>same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the brain</u> 1450 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>56</u> , to <u>Dec. 23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 23</u> , 19 <u>59</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harold C. Grott M.D. 8100 Harford Rd. 12/23/59</u> ACTUAL SIGNATURE <u>H. A. GOTT, M.D. Balto 14, MD</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



13462

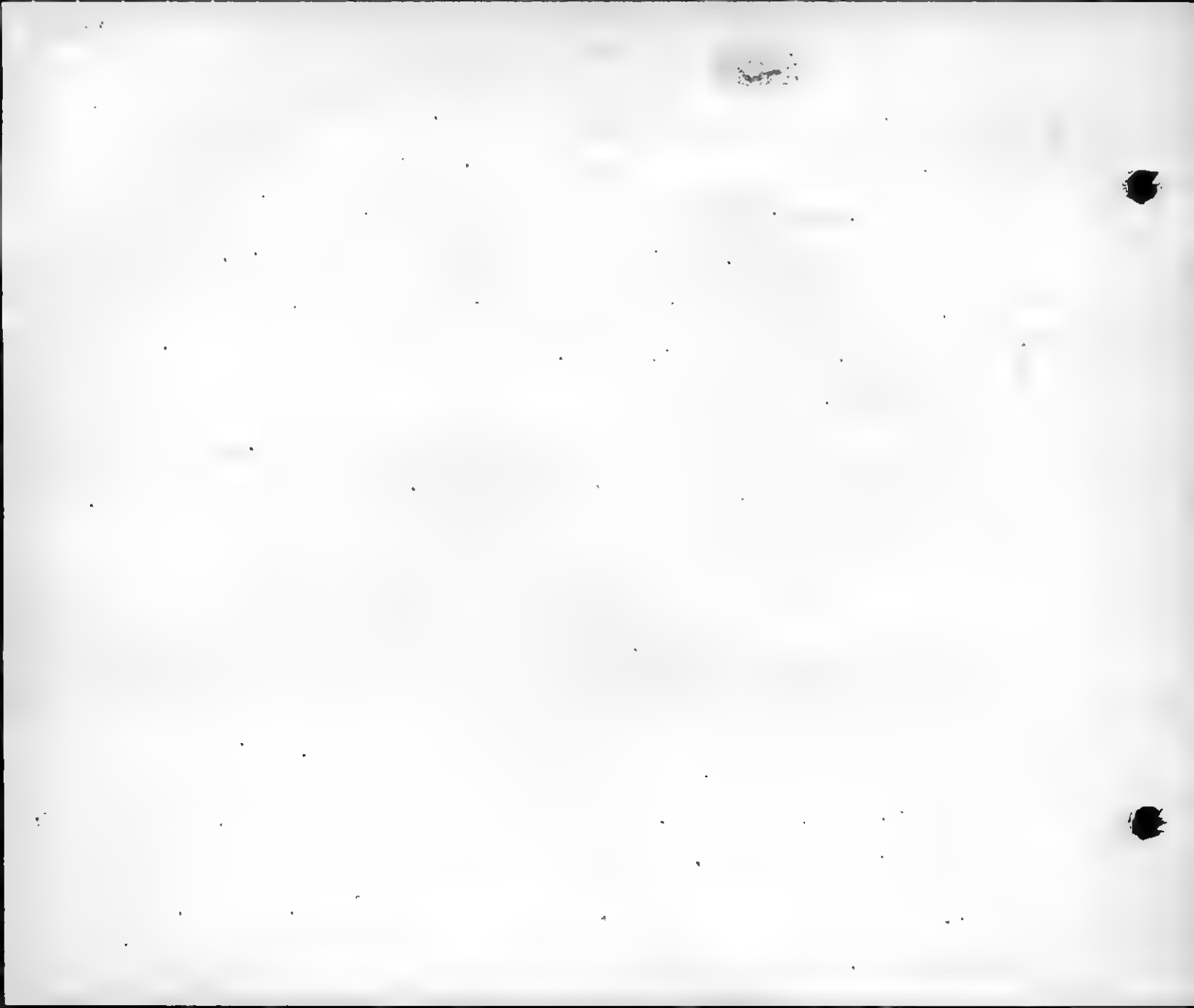
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>938 Ellendale Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ray W.</u> Middle <u>Pitts</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>water dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles L. Pitts</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Burnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
INFORMANT <u>Ethel Niemeyer</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CEREBRO-VASCULAR DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>DEC 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC 13</u> , 19 <u>59</u> , and that death occurred at <u>1250 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		ADDRESS (Street, city or town, state) <u>TIMONIAN, MD.</u>	
DATE SIGNED <u>12/22/59</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jessup Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kugel</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13463

CERTIFICATE OF DEATH

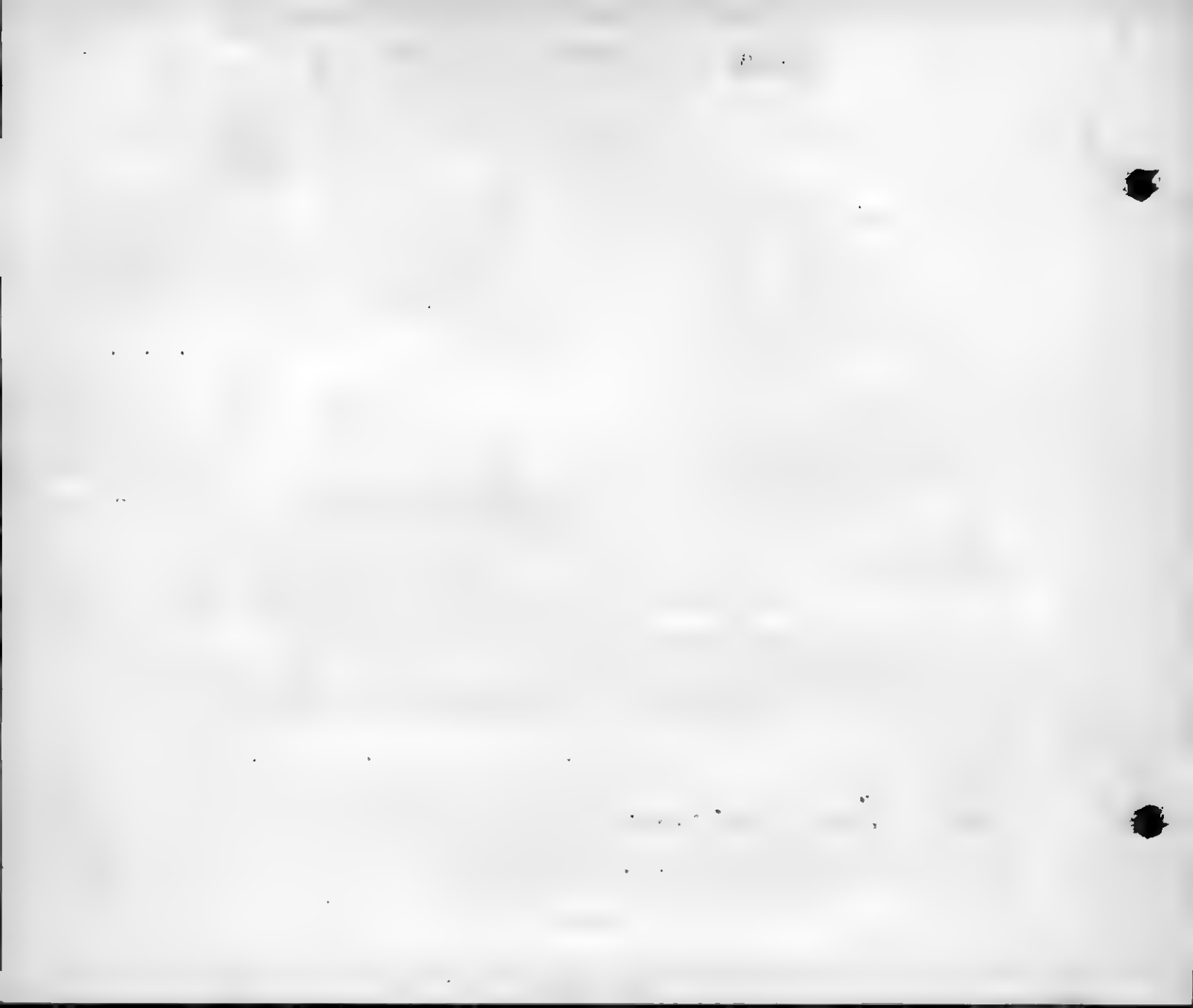
13441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle A. Last Pledge		4. DATE OF DEATH Month December Day 20 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.F. & H	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James L Amos		14. MOTHER'S MAIDEN NAME Annie Gates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 217-01-2701	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia with pleural empyema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic and acute alcoholism			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 18, 19 59 to Dec. 20, 19 59 , that I last saw the deceased alive on Dec. 20, 19 59 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED 12-21-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY Louisa Park		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Coughlin 5311 Edmondson Ave		24a. REC'D BY REGISTRAR DEC 23 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

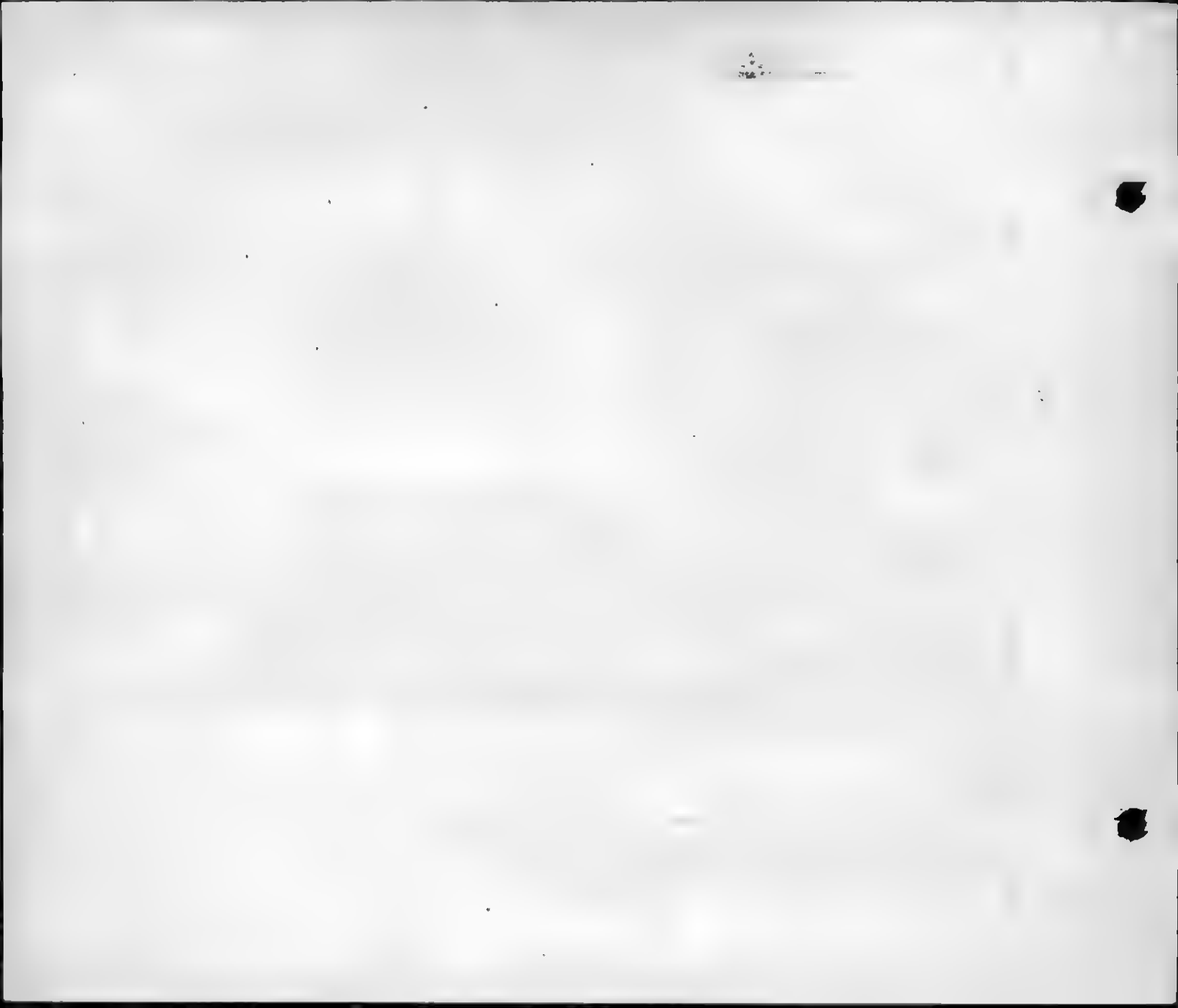
Item 7 Film 6253 12-14-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 13442

13464

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MD. b. COUNTY 7	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VILLA NOVA		c. LENGTH OF STAY IN 1b 1 1/2 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		d. STREET ADDRESS ROGERS AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AUGSBURG HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle PLEINES Last		4. DATE OF DEATH Month DEC. Day 9, Year 59 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 10, 1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR: Months 9 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) SHREWSBURY PA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES		14. MOTHER'S MAIDEN NAME ROSA BECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO ---	
17. INFORMANT RECORDS AUGSBURG HOME 6811 CAMPFIELD		Address Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Senile Psychosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Psychosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
19. INTERVAL BETWEEN ONSET AND DEATH 5 yrs 6 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 23, 1958 , to Dec. 9, 1959 , that I last saw the deceased alive on Dec. 4, 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts	
PHYSICIAN'S NAME (Type) Paul L. Chambers		DATE SIGNED 12/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heemahn		ADDRESS 6067 Harford Rd.	
24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	



13465

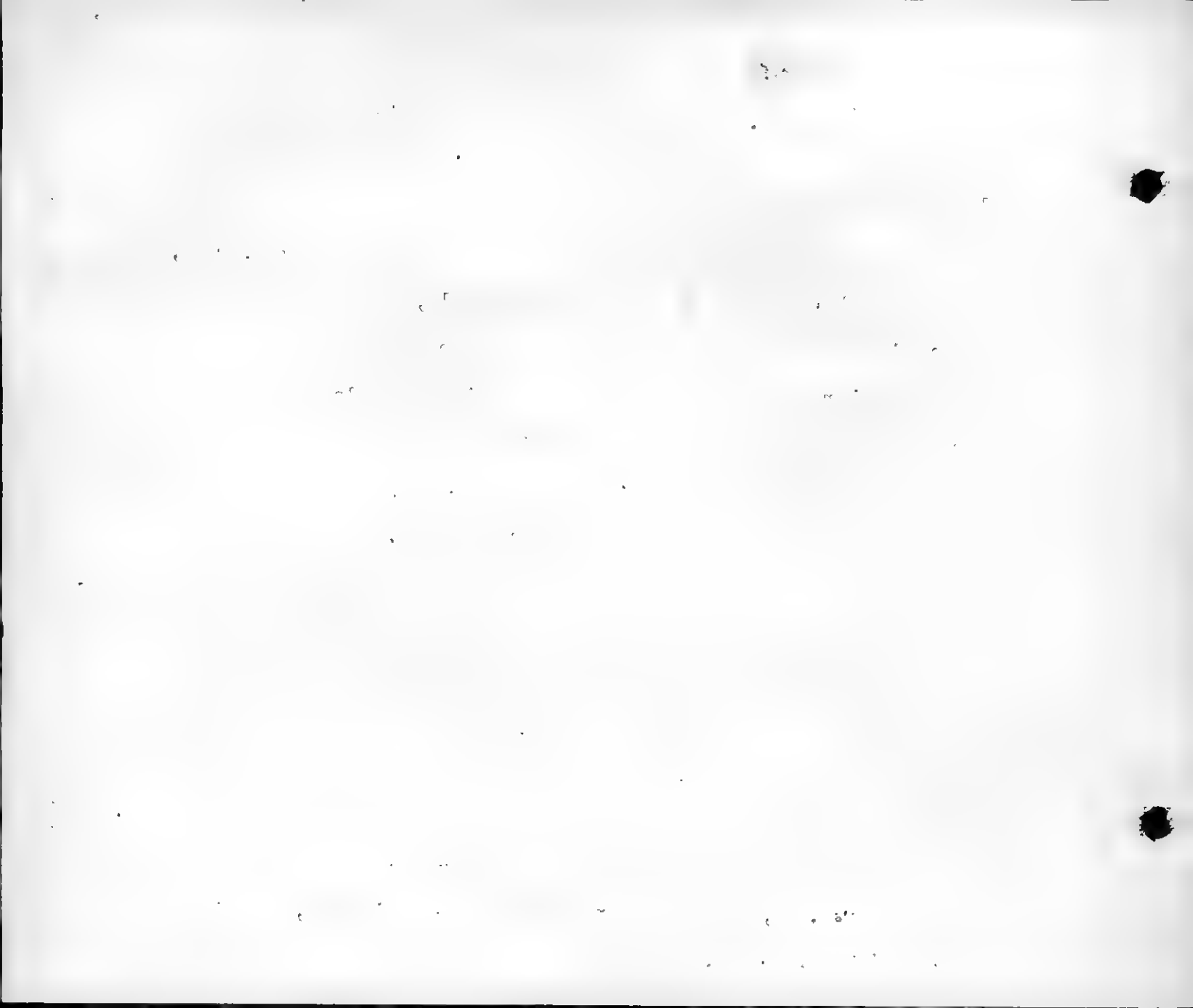
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Georgia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1817 Cromwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle BARBER Last POWERS		4. DATE OF DEATH Month December Day 29, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1887
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Barber		14. MOTHER'S MAIDEN NAME Helen Circopley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO Family Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) CORONARY HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH MINUTES MINUTES YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/2/59 to 12/29/59 , that I last saw the deceased alive on 12/2/59 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald L. Somerville M.D.		ADDRESS (Street, city or town, state) 25 W. Pa. Ave DATE SIGNED 12/30/59	
PHYSICIAN'S NAME (Type) Donald L. Somerville, M.D.		Towson 4, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Dec. 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Henderson Funeral Home	22d. LOCATION (City, town, or county) (State) Savannah, Georgia
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE JAN 4 '60	24b. REGISTRAR'S SIGNATURE Carling S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

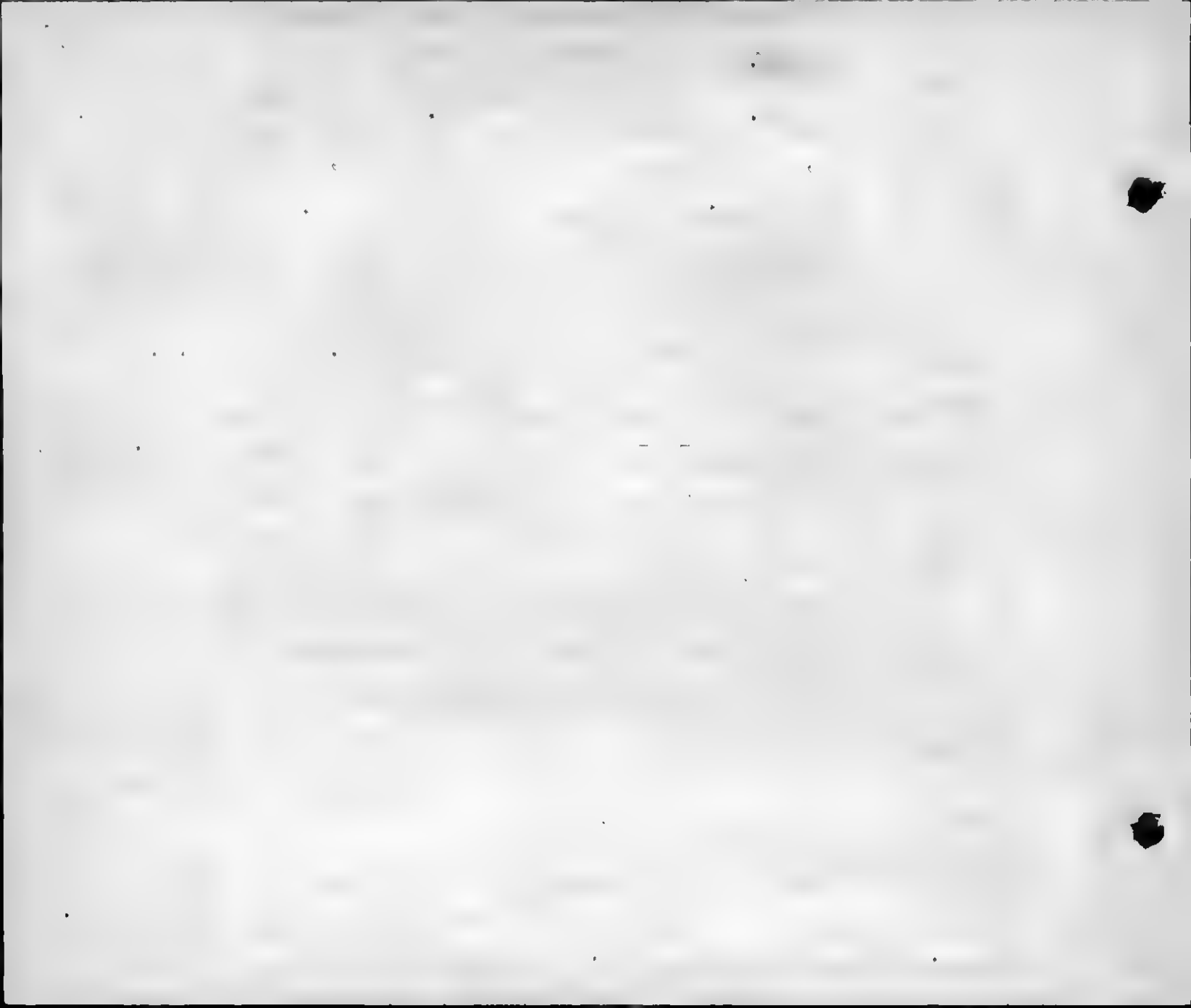
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13466

CERTIFICATE OF DEATH

Reg. Dist. No. 13444

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1625 Searles Rd.		d. STREET ADDRESS 18330 Bletzer Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle PURAL Last		4. DATE OF DEATH Month 12 Day 21 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Stevedore	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Joseph Pural		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 214-01-0763A	
17. INFORMANT Joseph Pural		Address 8330 Bletzer Rd. (22)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Left Lung. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma to Liver. DUE TO (c) Hypertensive C.V.D. Anteriorly & Posteriorly		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from her , 19 59 , to Dec 21 , 19 59 , that I last saw the deceased alive on 12/21/59 , 19 59 , and that death occurred at 12:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Melvin J. Jaworski		DATE SIGNED 12/21/59	
PHYSICIAN'S NAME (Type) MELVIN J. JAWORSKI M.D.		2711 EASTERN AVE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) 7401 German Hill Rd Ba. Co	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc		ADDRESS 401 S. Chester St.	
24a. REC'D BY REGISTRAR DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krone	



13467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson Convalescent Home d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 W. Chesapeake Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. d. STREET ADDRESS 4225 Loch Raven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Reinhardt		4. DATE OF DEATH Month Dec. Day 23 Year 19 59	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 20, 1871
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Owens Ill. Glass Co.		10b. KIND OF BUSINESS OR INDUSTRY Glass Co.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Reinhardt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Blvd		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerosis C.V. Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1952 , to Dec 23 1959 , that I last saw the deceased alive on Dec 22 1959 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1039 St Paul St DATE SIGNED 12/24/59 ACTUAL SIGNATURE Lester A. Wall Jr M.D. PHYSICIAN'S NAME (Type) LESTER A. WALL JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/59	
22c. NAME OF CEMETERY OR CREMATORY Londox Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.		24a. REC'D BY REG. STRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

13468

CERTIFICATE OF DEATH

Reg. Dist. No.

13446

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				d. STREET ADDRESS <u>Glenarm Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Leontine Reinisch</u>				4. DATE OF DEATH Month Day Year <u>Dec 19 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1890</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Reinisch</u>				14. MOTHER'S MAIDEN NAME <u>Mary Loeffler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-renal vascular disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 6, 1950</u> to <u>December 19, 1955</u> , that I last saw the deceased alive on <u>December 1, 1955</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7701 Park Road Towson, Md.</u> DATE SIGNED <u>12/2/55</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NE TOWSON, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Giler</u>				ADDRESS <u>9015 CONKLING ST. BALTIMORE, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13469

CERTIFICATE OF DEATH

Reg. Dist. No.

13447

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FACKLER - 5049.1113</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1308 N. VOLFE ST. - BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8344 LIBERTY RD</u>				d. STREET ADDRESS <u>1308 N. VOLFE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>VERONA</u> Last <u>RENNER</u>			4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/02</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - NL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM C. HIDEY</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE GLADMON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>XXX</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>MRS. HOFFMAN</u> Address <u>8344 LIBERTY RD BALTIMORE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF OVARY - METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>OCT. 12, 1959</u> , to <u>DEC. 4, 1959</u> , that I last saw the deceased alive on <u>DEC. 4, 1959</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin Z. Pieppert</u> M.D. <u>8204 LIBERTY RD, BALTIMORE, MD</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>12/4/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN Z. PIEPPERT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens</u> ADDRESS <u>1308 N. VOLFE ST. - BALTIMORE</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



13470

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, 28 c. LENGTH OF STAY IN 1b 28 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 621 Rest Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, 28 d. STREET ADDRESS 621 Rest Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John William Rest				4. DATE OF DEATH Month Day Year Dec 25 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/26/1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman				10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John W. Rest				14. MOTHER'S MAIDEN NAME Family records 621 Rest Ave			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Family records 621 Rest Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4:30 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Balto. Co. Ind				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12-15 , 19 59 , to 12-25 , 19 59 , that I last saw the deceased alive on 12-22 , 19 59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 410 North Ave DATE SIGNED 12 26 59 ACTUAL SIGNATURE Thomas F Herbert M.D. PHYSICIAN'S NAME (Type) Thomas F Herbert M.D. Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY Torrance Park		22d. LOCATION (City, town, or county) (State) Balto. Co. Ind	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kneud				ADDRESS 28		24a. REC'D BY REGISTRAR DATE DEC 29 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneud							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13471

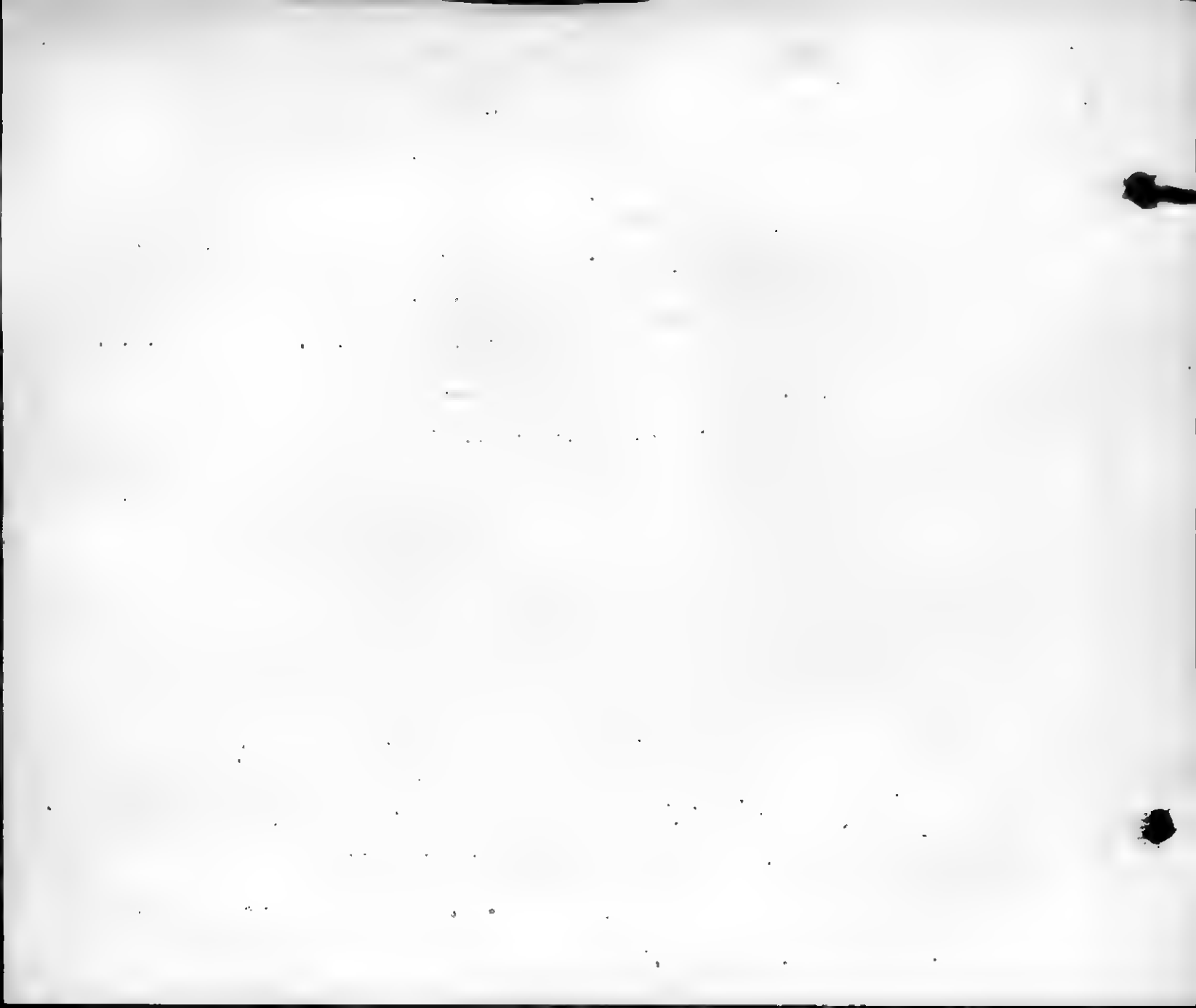
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodensburg		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodensburg		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle W. Last Rhoten		4. DATE OF DEATH Month December Day 19 Year 19 59		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1923		9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest E. Wooden		14. MOTHER'S MAIDEN NAME Lois Benson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-24-2513	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Amelanotic melanoma		INTERVAL BETWEEN ONSET AND DEATH 28 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Dec 12 , 19 57 , to Dec 19 , 19 59 , that I last saw the deceased alive on Dec 19 , 19 59 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Reisterstown, Maryland		DATE SIGNED Dec 20, 1959		ACTUAL SIGNATURE Clarence E. McWilliams M.D.		PHYSICIAN'S NAME (Type) Clarence E. McWilliams Reisterstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-22-59		22c. NAME OF CEMETERY OR CREMATORY Woodensburg Cemetery		22d. LOCATION (City, town, or county) Woodensburg, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 7 Film 6254 1-4-60 et 13472 13450 Reg. Dist. No.

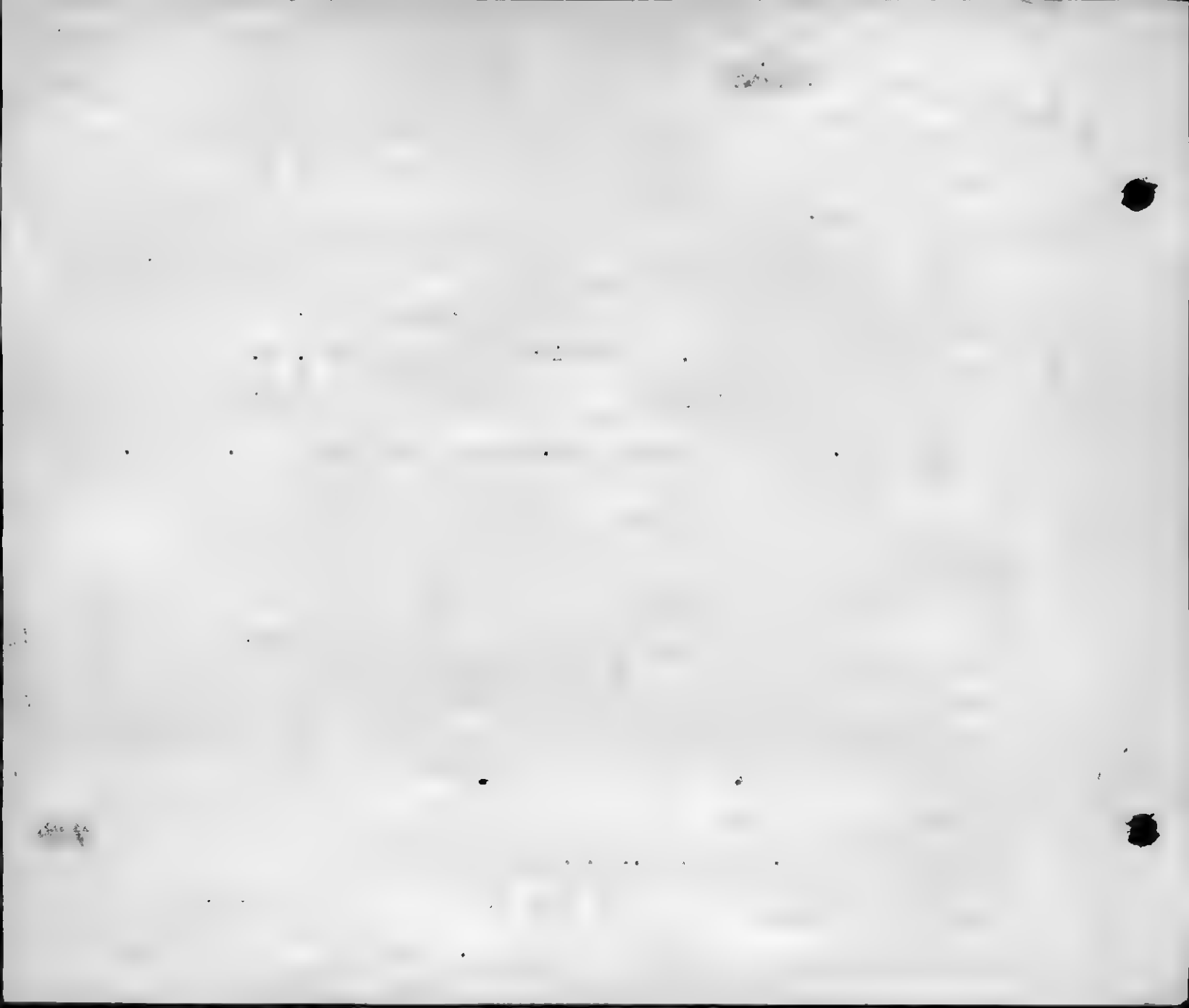
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 East Burke Ave.</u>				d. STREET ADDRESS <u>20 East Burke Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Rick</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1898</u>	9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANDALYN INC</u>		11. BIRTHPLACE (State or foreign country) <u>SPARROWS TX. TX.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Mc Mann</u>				14. MOTHER'S MAIDEN NAME <u>Nona McCleary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-4789</u>		17. INFORMANT <u>George C. Rick</u>		Address <u>20 E. BURKE AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of ovary (right)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>54</u> , to <u>12/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>59</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8523 Loch Raven Blvd</u>						DATE SIGNED <u>12/21/59</u>	
ACTUAL SIGNATURE <u>Edward Gordon Gray</u>				M.D. <u>8523 Loch Raven Blvd</u>			
PHYSICIAN'S NAME (Type) <u>Edward Gordon Gray</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc. - 2431 E. Oliver St</u>				24a. REC'D BY REGISTRAR <u>DEC 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

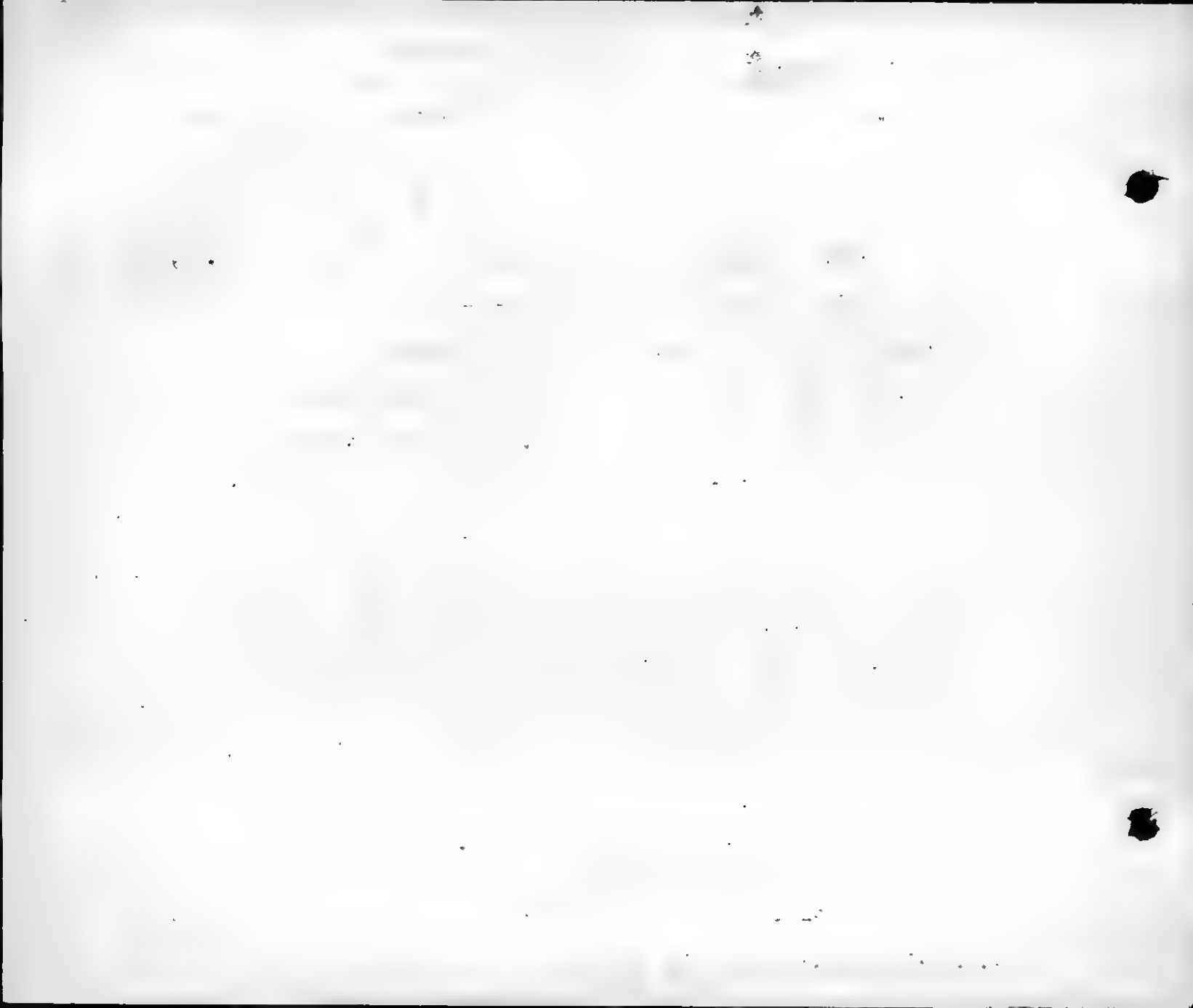




TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13452
RELEASED ON APPROVAL 13474										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Oella Ave					d. STREET ADDRESS 102 Oella Ave					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MINNIE Middle RILEY Last					4. DATE OF DEATH Month Dec. Day 21 Year 1959					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-1889		9. AGE (In years last birthday) 70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Charles Back					14. MOTHER'S MAIDEN NAME Mary Back					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Walter Green, Catonsville, Md			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 ACUTE PULMONARY EDEMA DUE TO (b) FRACTURED LEFT HIP DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DIABETES, OBESITY										INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 1 HOUR NOT KNOWN
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SLIPPED ON FLOOR AT HOME, AND FELL							
20c. TIME OF INJURY Month, Day, Year 2:00 p.m. 12-21 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) OELLA, BALTO., MD.			
21. I certify that I attended the deceased from 12-21 1959 , to 12-21 1959 , that I last saw the deceased alive on 12-21 1959 , and that death occurred at 3 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA ROAD ELLICOTT CITY, MD. DATE SIGNED 12-22-59										
ACTUAL SIGNATURE Peter V. Thorpe M.D.										
PHYSICIAN'S NAME (Type) PETER V. THORPE, MD ELLICOTT CITY, MD.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md					24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13475

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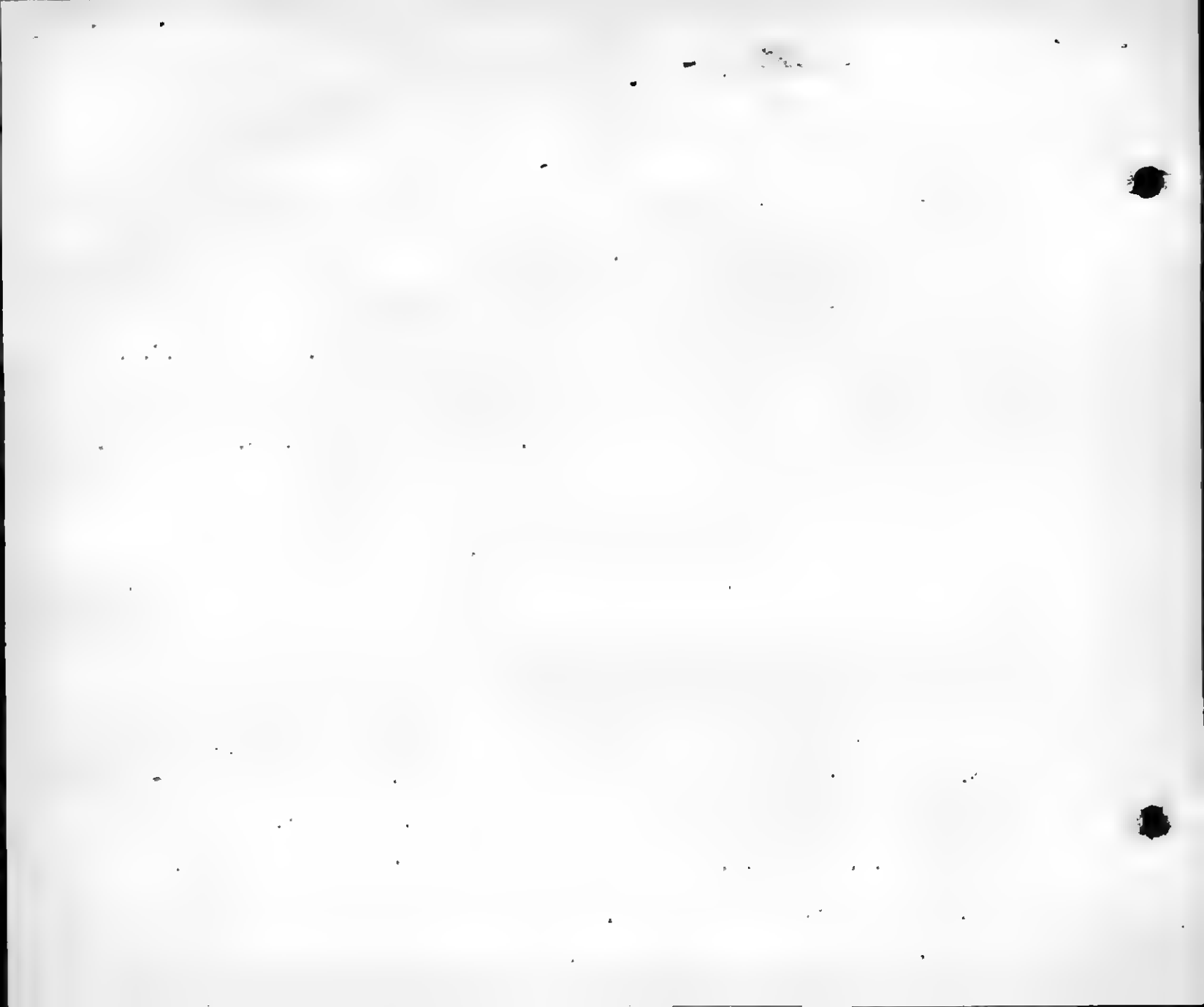
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle K. Last RINGLE				4. DATE OF DEATH Month December Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1895	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Granville, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Ringle				14. MOTHER'S MAIDEN NAME Anna Switzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 705-05-0892			
INFORMANT Clin. Records VAH Balto, Md., Ft. Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONITIS 496 x Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOSIS OF BRANCH OF RIGHT MIDDLE CEREBRAL ARTERY WITH LEFT HEMIPLEGIA (c) CEREBRAL ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 1 MONTH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 11, 1959 to December 12, 1959 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. J. R. Hood				ADDRESS (Street, city or town, state) VAH, BALTO. MD. FORT HOWARD DIVISION			
DATE SIGNED 12/13/59							
PHYSICIAN'S NAME (Type) T.R. HOOD, M.D.				VAH, BALTO, MD. FORT HOWARD DIVISION 12/13/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-59		22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. 6009 Harford Rd.				24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13476

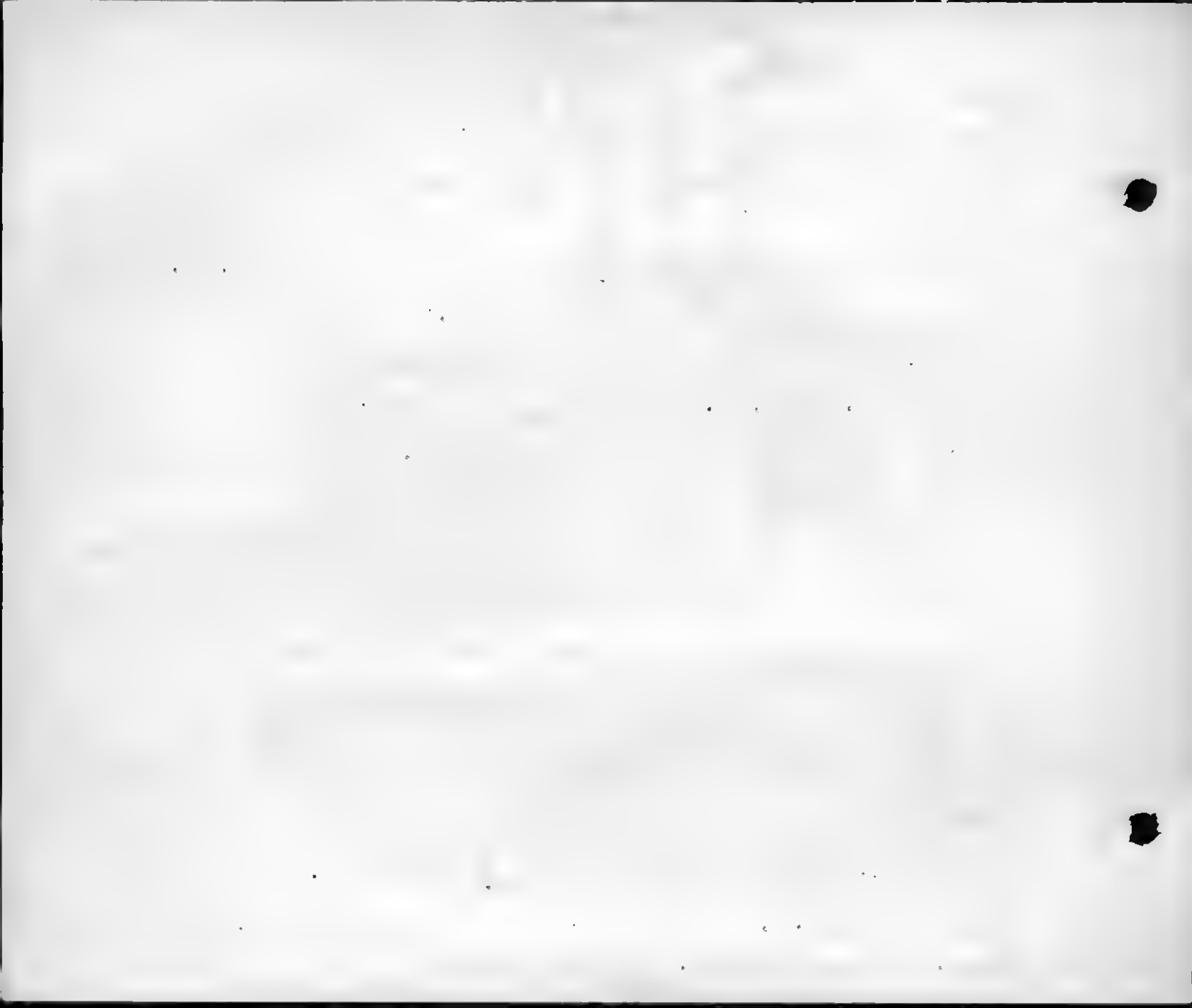
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>6 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE NELSON ROGERS</u>				4. DATE OF DEATH <u>December 2, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Radio</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William F. Rogers, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Holloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Marion D. Rogers</u>		Address <u>1518 Bolton Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Cordeas to mylg</u> 4:11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Coronary Thrombosis - Ant. sclerosis - 1 week</u> DUE TO (c) <u>Seriously</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 17, 1959</u> to <u>Dec. 2, 1959</u> , that I last saw the deceased alive on <u>Dec. 2, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Bernard J. Cohen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Bernard J. Cohen</u>				<u>Marylander Apts.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>				ADDRESS <u>1900 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>DEC 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina L. Hanna</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
5M 7/59

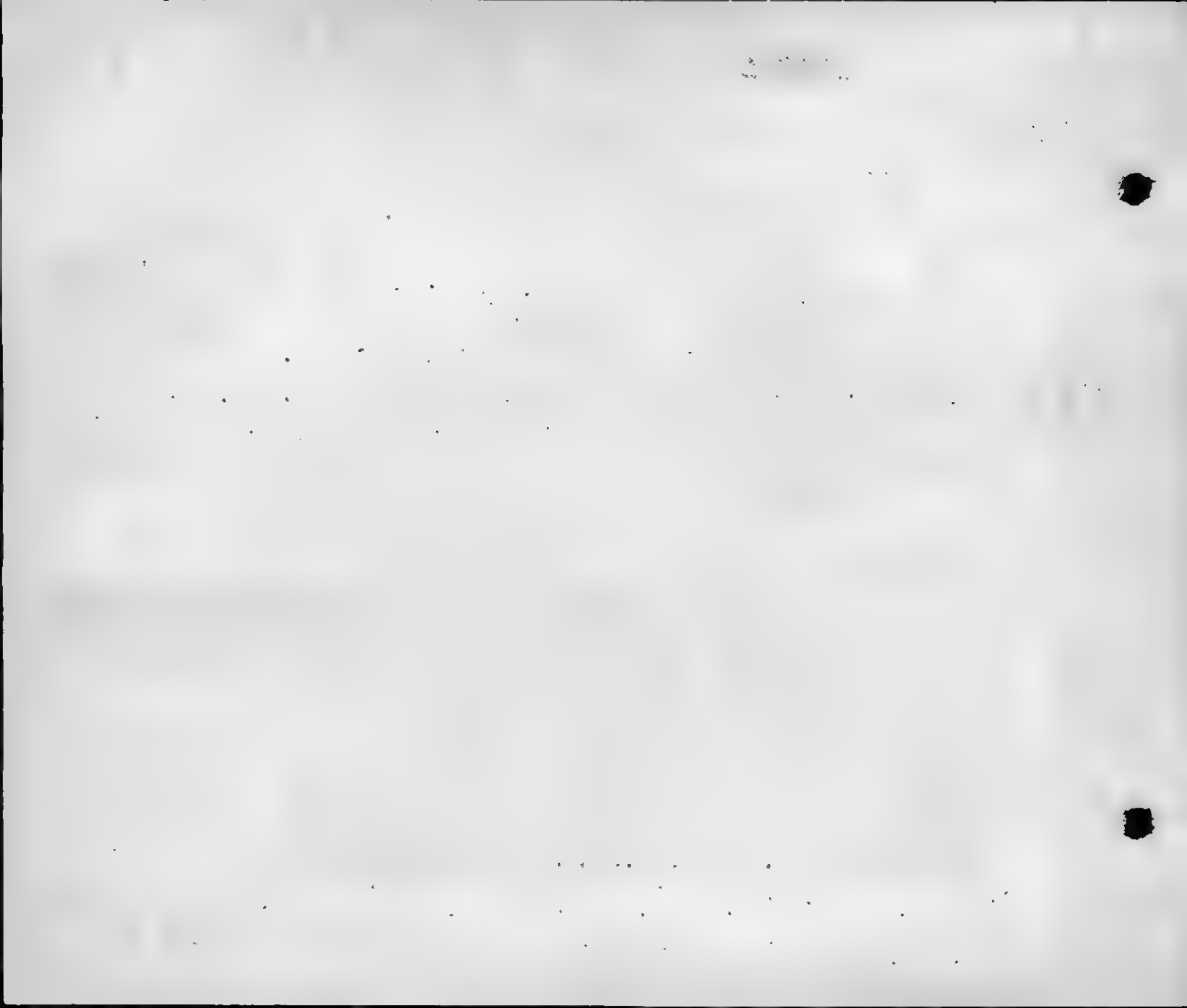
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13455

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ashford and Harwood			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 902 N. Central Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WARREN First Middle Last			4. DATE OF DEATH December 17, 1959 Month Day Year				
5. SEX Male			6. COLOR OR RACE Colored			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 2/14/1902			9. AGE (In years last birthday) 57 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (State or foreign country) Pitt Co., N.C.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Levy Rollins			14. MOTHER'S MAIDEN NAME Liddie Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 230014248			17. INFORMANT Lillie Adams Address 1304 Colonial Greenville, N.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Coronary insufficiency DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/19/59		22c. NAME OF CEMETERY OR CREMATORY Brown Hill		22d. LOCATION (City, town, or country) (State) Greenville N.C.	
23. FUNERAL DIRECTOR Arlington S. Phillips				24a. REC'D BY REGISTRAR DEC 21 '59			
ADDRESS 1808 N. Montgomery				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knap</i>			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

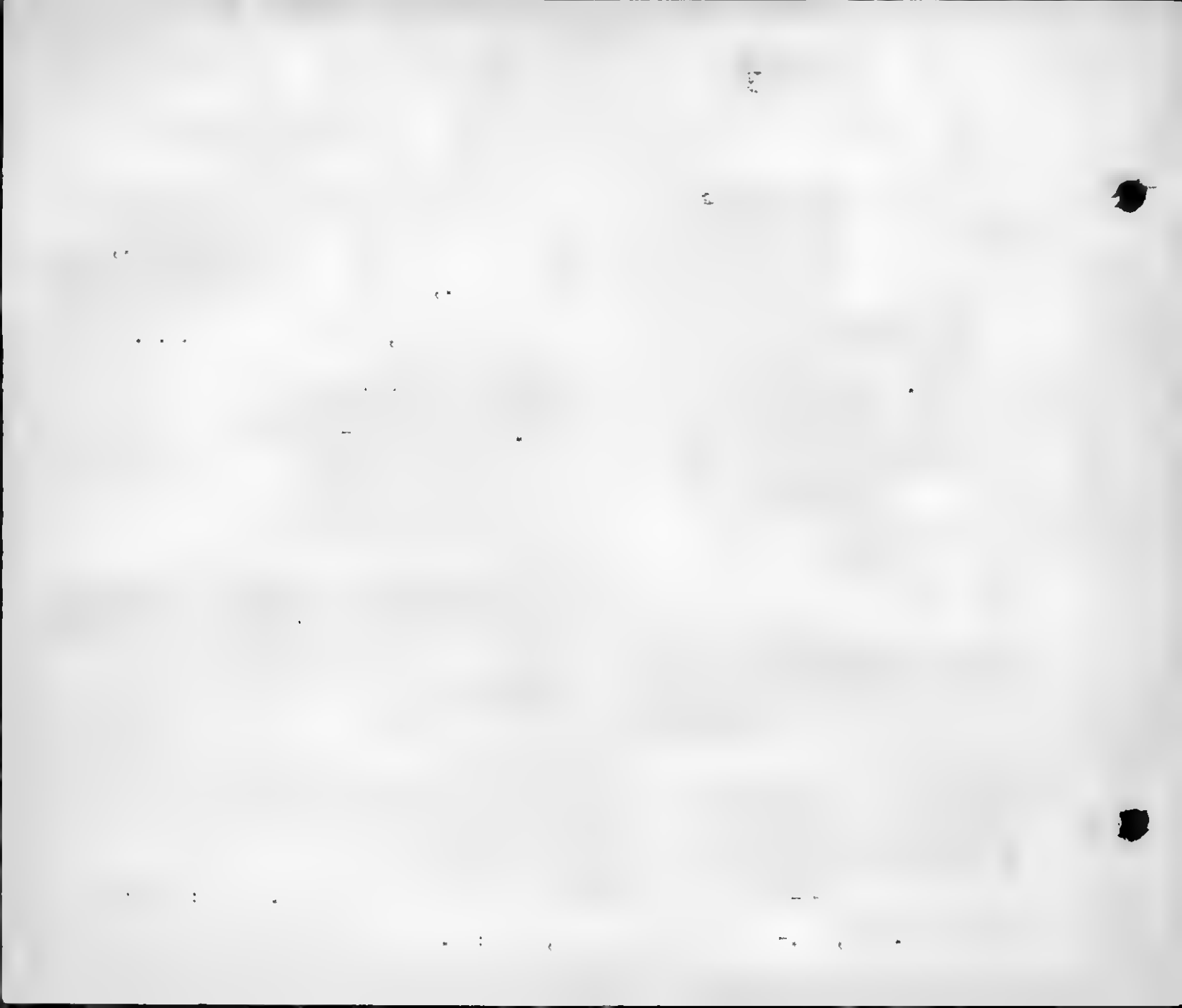
Reg. Dist. No. 13456

13478

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2913 Edgewood Avenue				d. STREET ADDRESS 2913 Edgewood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Romans				4. DATE OF DEATH Month December Day 6th. Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 16th., 1886		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 11 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Schaffer				14. MOTHER'S MAIDEN NAME Anna Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Bernard Farace-2913 Edgewood Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Cerebro-vascular Thromboses DUE TO Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Age + diabetic history. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Moderately severe Internal Hemorrhoidal Bleeding							INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 55 to Dec , 19 59 , that I last saw the deceased alive on Dec , 19 59 , and that death occurred at 8:15 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9005 HARFORD Rd. DATE SIGNED 12/6/59 ACTUAL SIGNATURE Frank T. Kasik Jr. M.D. PHYSICIAN'S NAME (Type) FRANK T. KASIK JR BALTO 14 Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1959		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Belair Rd. Balto: Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.-1735 Harford Avenue, Balto: Md.				24a. REC'D BY REGISTRAR DATE DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13457

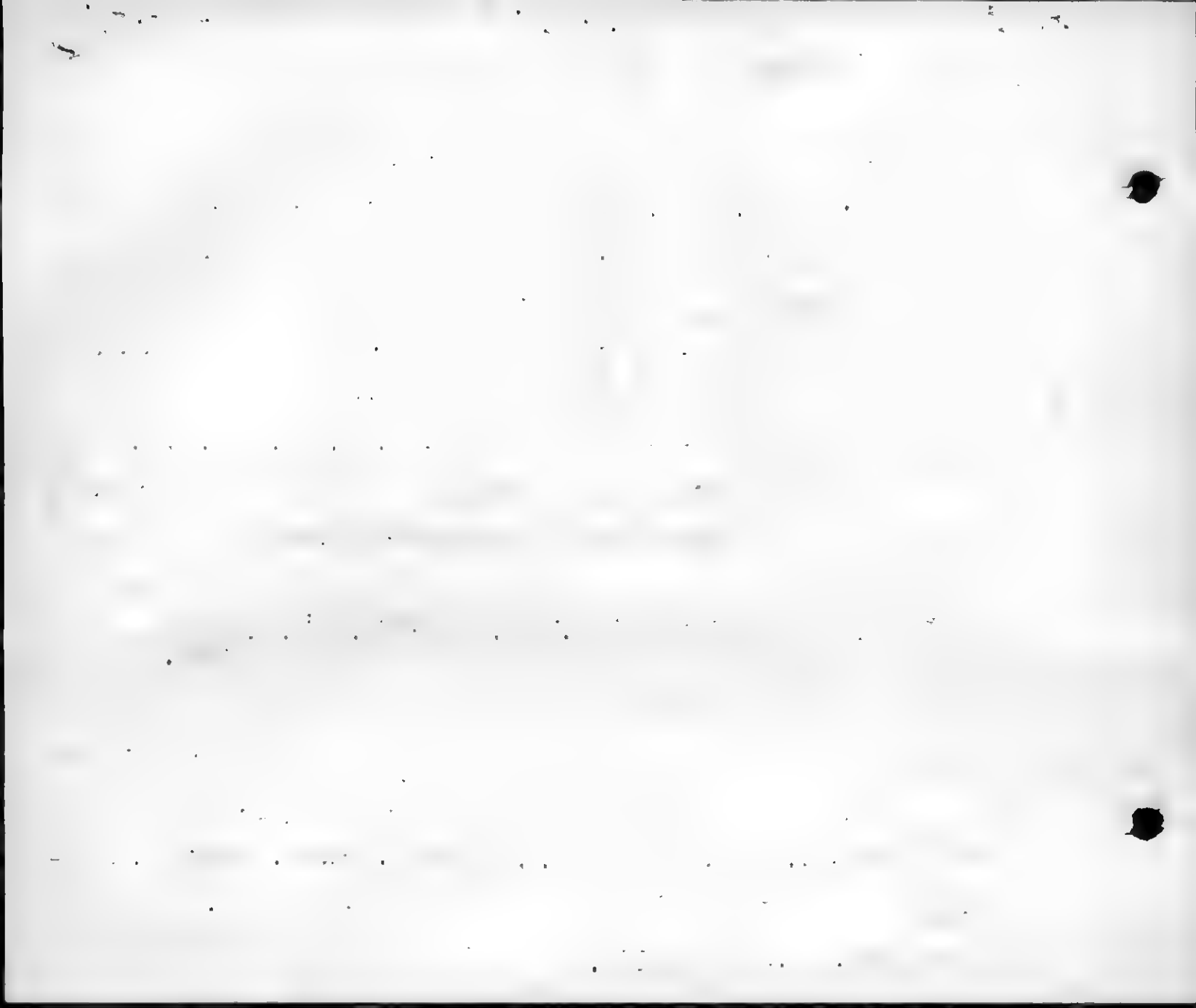
13479

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY L. J.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 169 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle L. Last ROOT		4. DATE OF DEATH Month DECEMBER Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1915
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14 Hours 14 Min 14	11. IF UNDER 24 HRS Months 4 Days 14 Hours 14 Min 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot-		10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	
11. BIRTHPLACE (State or foreign country) Burlington, Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Root		14. MOTHER'S MAIDEN NAME Eulia Barttro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL 28 095-10-2711	
17. INFORMANT Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). CEREBRAL THROMBOSIS WITH ENCEPHALOMALACIA OF RT TEMP LOBE; OLD POST. & APICAL MYO. INFARCTS; HEMORRHAGES SM. & LG. BOWEL; PASS. CONGEST. LIVER; ASCVD.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ASCVD.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1959 to December 19, 1959 , that I was the attending physician, and that death occurred at 10:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. Cillo		ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD. - FT HOWARD DIV 12/19/59	
PHYSICIAN'S NAME (Type) Joseph J. Cillo,		M.D. VAH, Balto., Md.-Ft. Howard Div. 12-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-21-59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	22d. LOCATION (City, town, or county) (State) Richmond, Vt.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., Baltimore, Md.		24a. REC'D BY REGISTRAR DEC 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



FOR STATE
HEALTH DEPT.

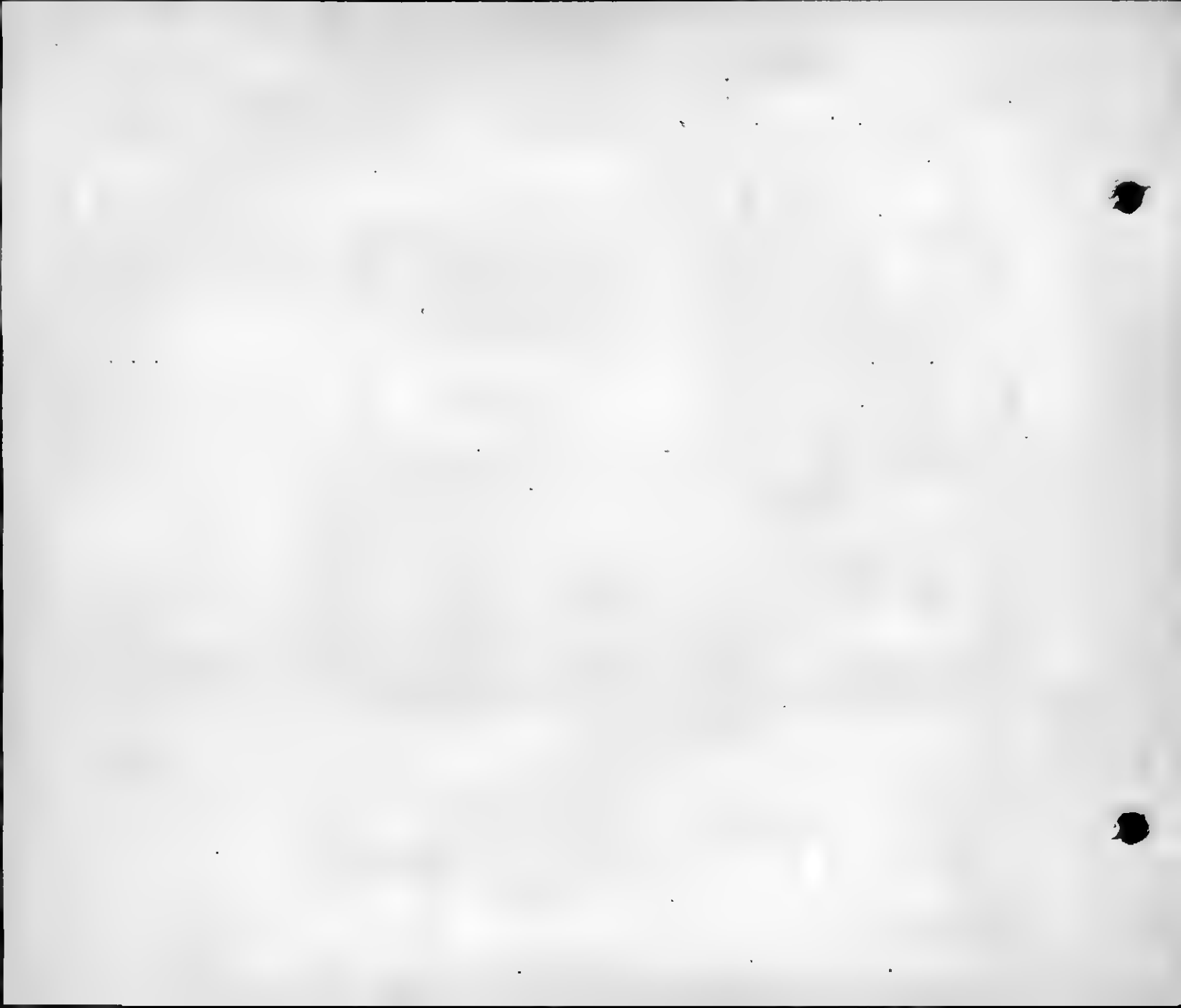
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River (Zone 20)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River (Zone 20)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 B Westway North</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Luther</u> Last <u>Rose</u>		4. DATE OF DEATH Day <u>December</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1932</u>
9. AGE (In years last birthday) <u>27 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tech. Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Virgil A. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Marie Davenport</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-42-4622</u>	
17. INFORMANT <u>Geneva Rose</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND - 25 CAL. PISTOL -</u> <u>976X</u> DUE TO (b) <u>RIGHT Temple - (Parital)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in Rt. Temple</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12-1-59</u> a. m. <u>10 AM.</u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Middle River - Md. Co. Ind</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Walton & Walton Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Greenbelt Co. W Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Buzgala</u>		24. RECEIVED BY REGISTRAR <u>DEC 3 '59</u>	
24a. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	
24c. ADDRESS <u>1407 Eastern Ave.</u>		DATE <u>DEC 3 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 File 6253 12-24-59 et

13333

CERTIFICATE OF DEATH

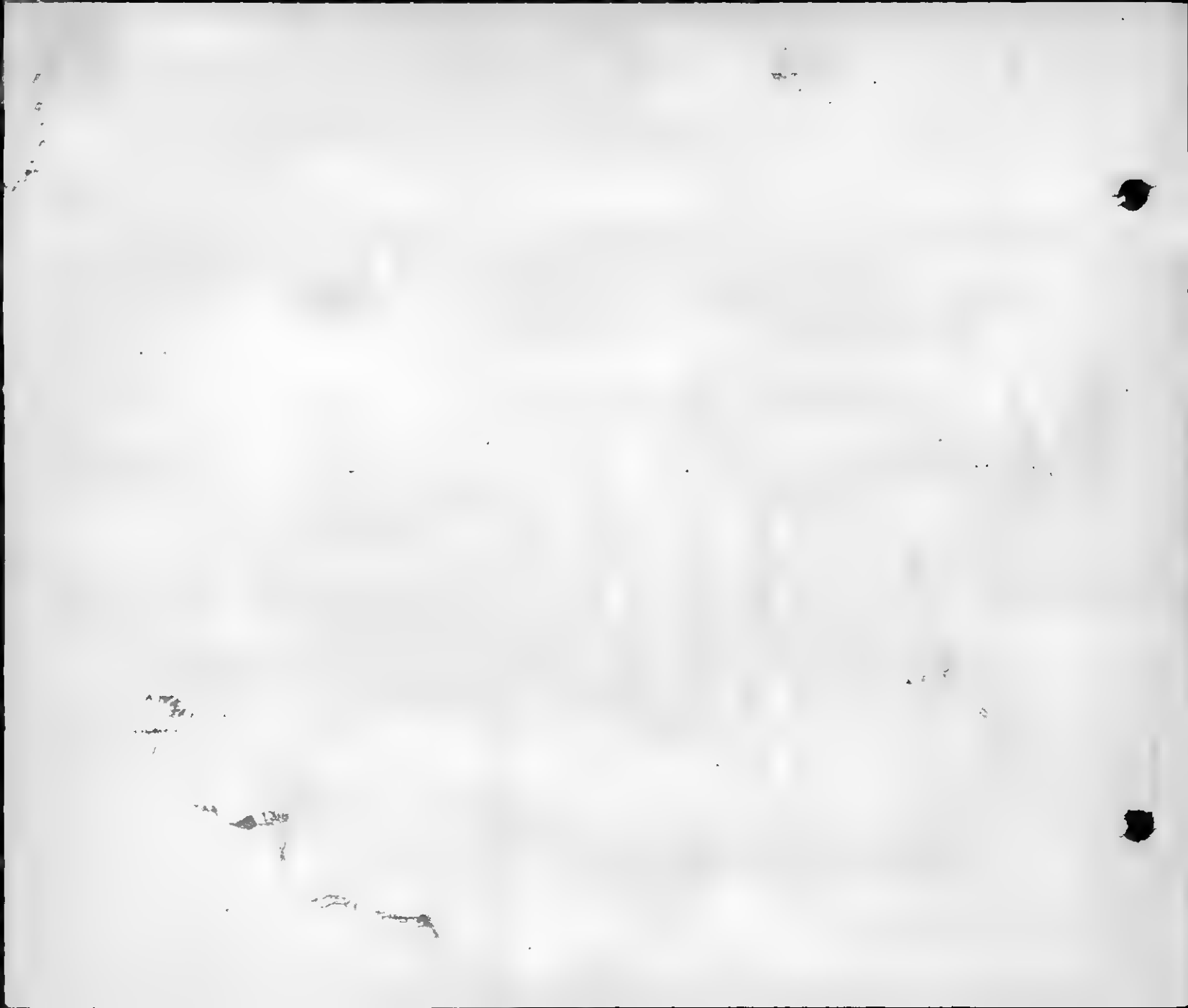
Reg. Dist. No.

13459

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Patapsco Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRENE Middle MARY Last ROSEL				4. DATE OF DEATH Month December Day 2 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1902	9. AGE (In years last birthday) 56 1/4 yrs.	IF UNDER 1 YEAR Months 5 Days 1 Hours 4 Min.	IF UNDER 24 HRS Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Trabert				14. MOTHER'S MAIDEN NAME Barbara Schreiber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Peter M. Rosel 11 Patapsco Ave. —22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease - 4 yrs DUE TO (c) None						INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1955 19 55 to Dec 19 59 , that I last saw the deceased alive on Nov. 20 19 59 , and that death occurred at 8:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6800 MERVINGTON AVE - DUNDALK - 22 MD DATE SIGNED 12/3/59							
ACTUAL SIGNATURE M. B. Davis		PHYSICIAN'S NAME (Type) M. B. Davis					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) Dundalk, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave., 22.				24a. REC'D BY REGISTRAR DEC 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13460

13481

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2101 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4116 Glenhunt Road	
3. NAME OF DECEASED (Type or print) First VICTOR Middle (NMI) Last RYBACKI		4. DATE OF DEATH Month DECEMBER Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/91
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Rybacki		14. MOTHER'S MAIDEN NAME Sophia (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-09-8222	
17. INFORMANT Clin. Records, Vets. Adm. Hosp. Balto, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONITIS DUE TO (b) CVA DUE TO (c) 231X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 16, 19 59 to December 10, 19 59 , and that death occurred at 2:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence J. Mazzei, M.D.		ADDRESS (Street, city or town, state) M.D. VAH, BALTIMORE, MD. FORT HOWARD DIVISION	
DATE SIGNED 12/10/59			
PHYSICIAN'S NAME (Type) LAWRENCE J. MAZZEI, M.D.		VAH, BALTO, MD. FORT HOWARD DIVISION 12/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Michael Sadowski		ADDRESS 1808 Eastern Avenue Baltimore, Maryland	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL HOME: This low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten text, possibly a signature or date, located near the bottom center of the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Filr G-254 1-8-60 et

CERTIFICATE OF DEATH

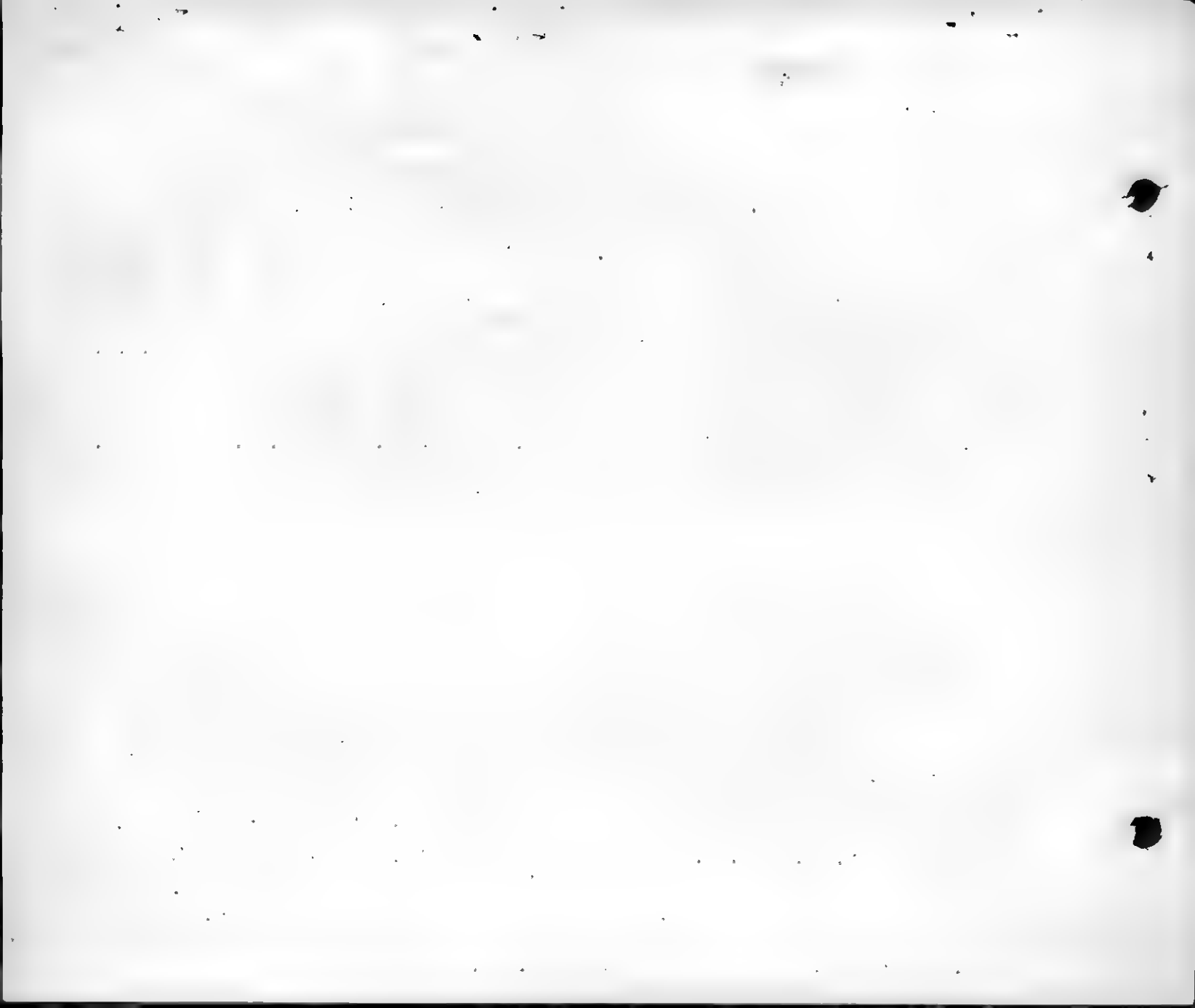
Reg. Dist. No.

13461

13482

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>101 days</u>				d. STREET ADDRESS <u>2230 Bank Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>FRANK</u> Middle <u>M.</u> Last <u>SAKOWSKI</u>		4. DATE OF DEATH <u>Dec. 20, 1959</u>		Month <u>20</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1909</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitcher Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sakowski</u>				14. MOTHER'S MAIDEN NAME <u>Frances Wisniewski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>213-09-3655</u>		INFORMANT <u>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPERNEPHROMA OF KIDNEY LEFT WITH EXTENSIVE METASTASES TO BOTH LUNGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>DUE TO</u> (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 10, 1959</u> to <u>12/20/59</u> and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Arce</u>		M.D. <u>VAH, BALTO. MD. FT HOWARD DIV.</u>		DATE SIGNED <u>12/20/59</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>S. ARCE, M. D.</u>		VAH, BALTO. MD. FT HOWARD DIV.		DATE <u>12/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski, 2007 Eastern Ave. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13483

13462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2420 YORK ROAD</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>TIMONIUM</u> d. STREET ADDRESS <u>2420 YORK ROAD</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VERNON CHARLES SANDERS, SR.</u>		4. DATE OF DEATH <u>DECEMBER 4, 1959</u>		5. SEX <u>MALE</u>	
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 18, 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERINTENDENT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWIN SANDERS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET SCHMIDT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>217-05-3245</u>		17. INFORMANT <u>FAMILY RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery insufficiency</u> DUE TO <u>2 months</u> (c) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. C. Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/5/59</u>	
EXAMINER'S NAME (Type) <u>Charles F. C. Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>TEXAS, BALTIMORE CO., MD</u>		22e. (State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13463

13484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mississippi</u> b. COUNTY <u>Walthal</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jayess</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2165 Lorraine Ave.</u>		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) <u>Hazel Emma Sartin</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10. 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>MS</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Harry L. Spencer</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Ball</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rev. Fred Sartin, Jayess, Miss</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		DATE SIGNED <u>Dec. 6, 1959</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Sartinsville, Mississippi</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fickner & Son - Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Clara L. Kane</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



13486

CERTIFICATE OF DEATH

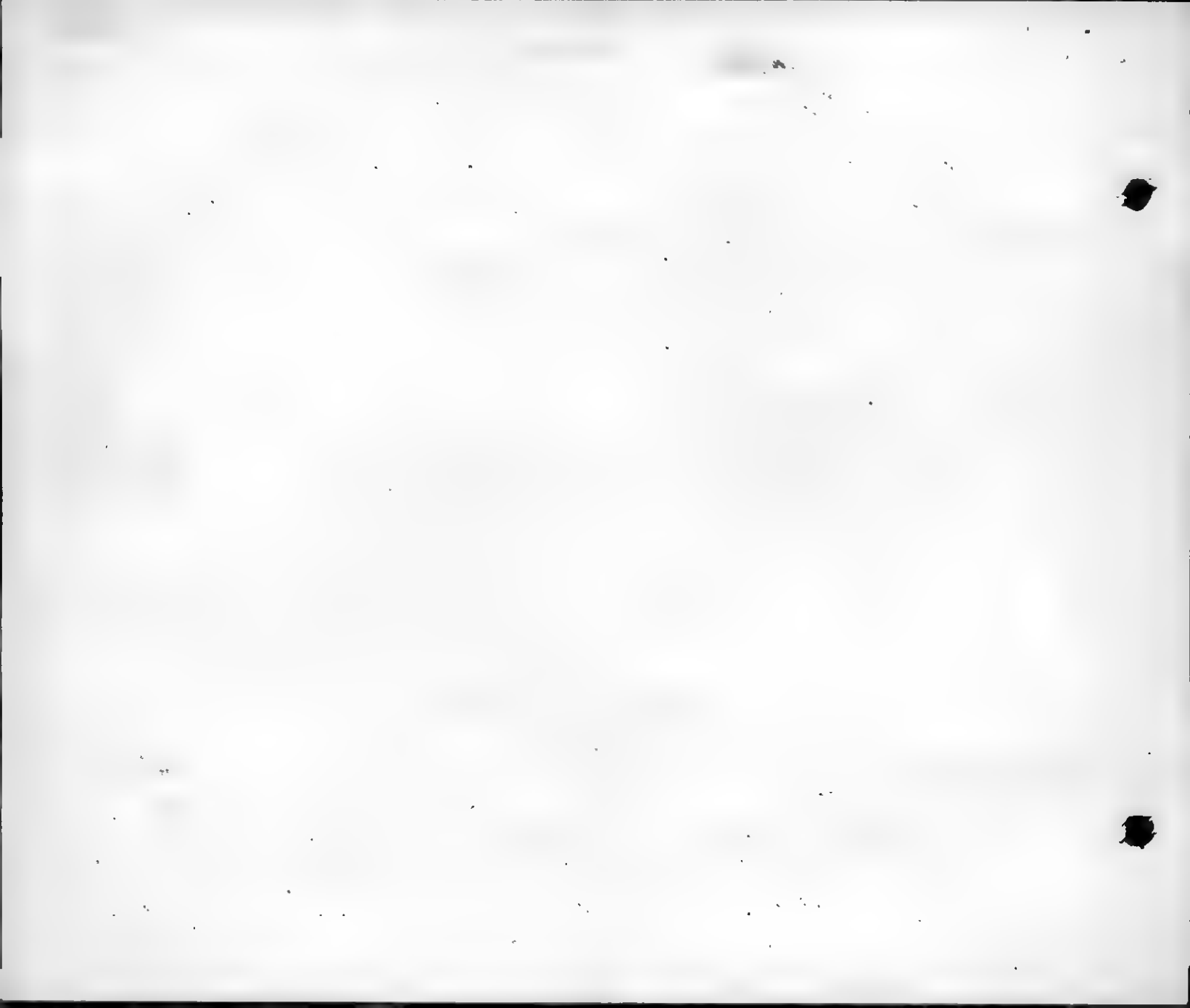
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3501 Overbrook Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Morris F. Scherlis</u> First Middle Last		4. DATE OF DEATH <u>12</u> <u>28</u> <u>1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Scherlis</u>		14. MOTHER'S MAIDEN NAME <u>Ethel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>524-01-1111</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 8</u> <u>1957</u> to <u>12/10/59</u> , that I last saw the deceased alive on <u>12/18/59</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>M. S. Shilling M.D.</u>		ADDRESS (Street, city or town, state) <u>2500 Eutanaw Place Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M. S. Shilling M.D.</u>		Balto 17, 724	
22a. BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/30/59</u>	<u>Bethel Long</u>	<u>North Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Brown - Bros Inc</u>		24a. REC'D BY REGISTRAR <u>6 '60</u>	
ADDRESS <u>4124-26</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

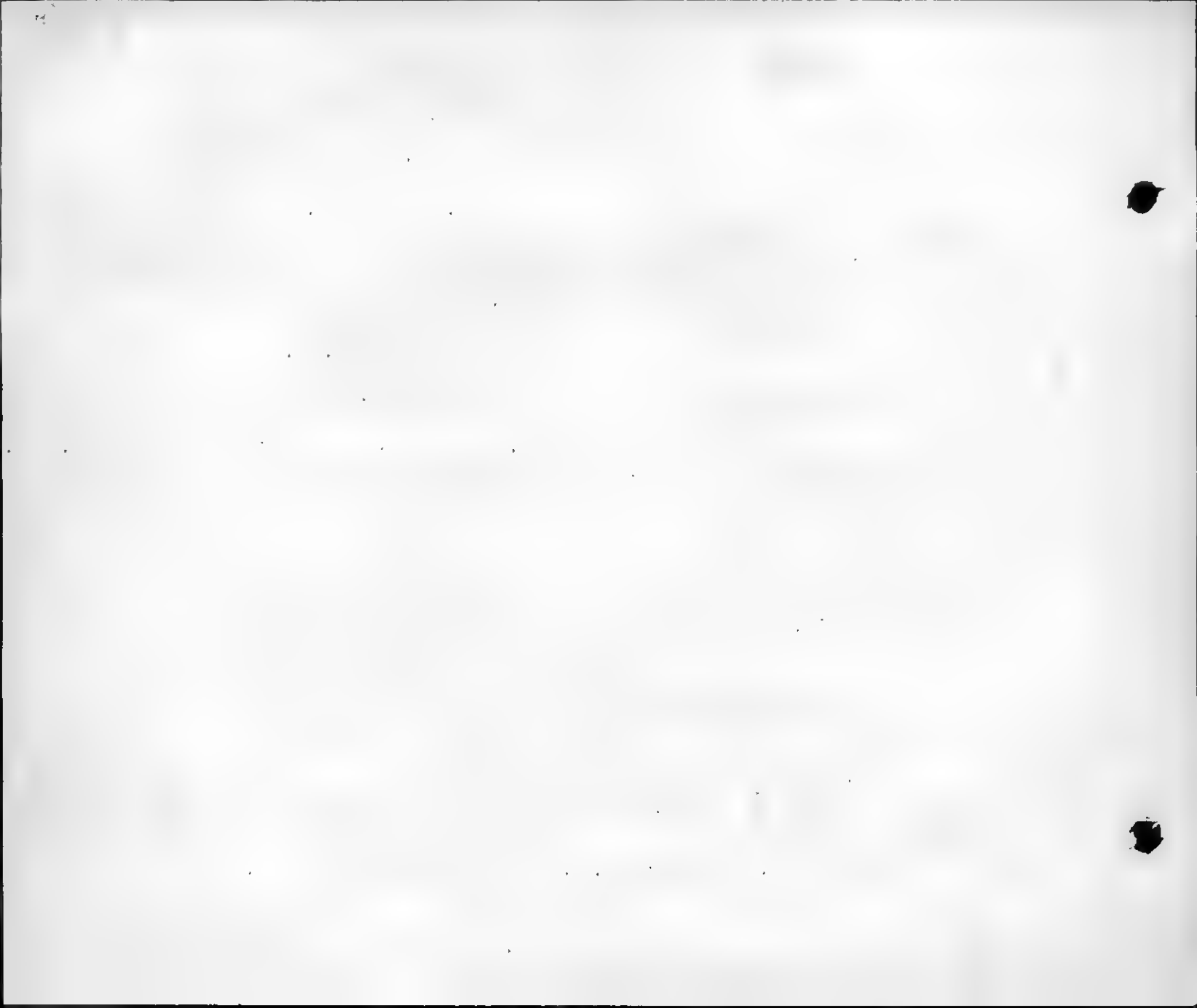
Reg. Dist. No.

13486

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				d. STREET ADDRESS 201 E. North Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH BODINE SCHMIDT				4. DATE OF DEATH Month Day Year December 28 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1872	
9. AGE (in years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Bodine				14. MOTHER'S MAIDEN NAME Eugenia E. Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mrs. Minnie Humphries-3124 Howard Pk. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Procidencia Rectum Recent. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 58 to 12/28/59 , that I last saw the deceased alive on 12/27/59 19, and that death occurred at 1000 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd (28) 12/29/59							
ACTUAL SIGNATURE William E. McGrath		M.D. 1303 Frederick Ave. - 28					
PHYSICIAN'S NAME (Type) William E. McGrath, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armatost-4600 Liberty Hghts. Ave				24a. REC'D BY REGISTRAR DEC 30 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13487

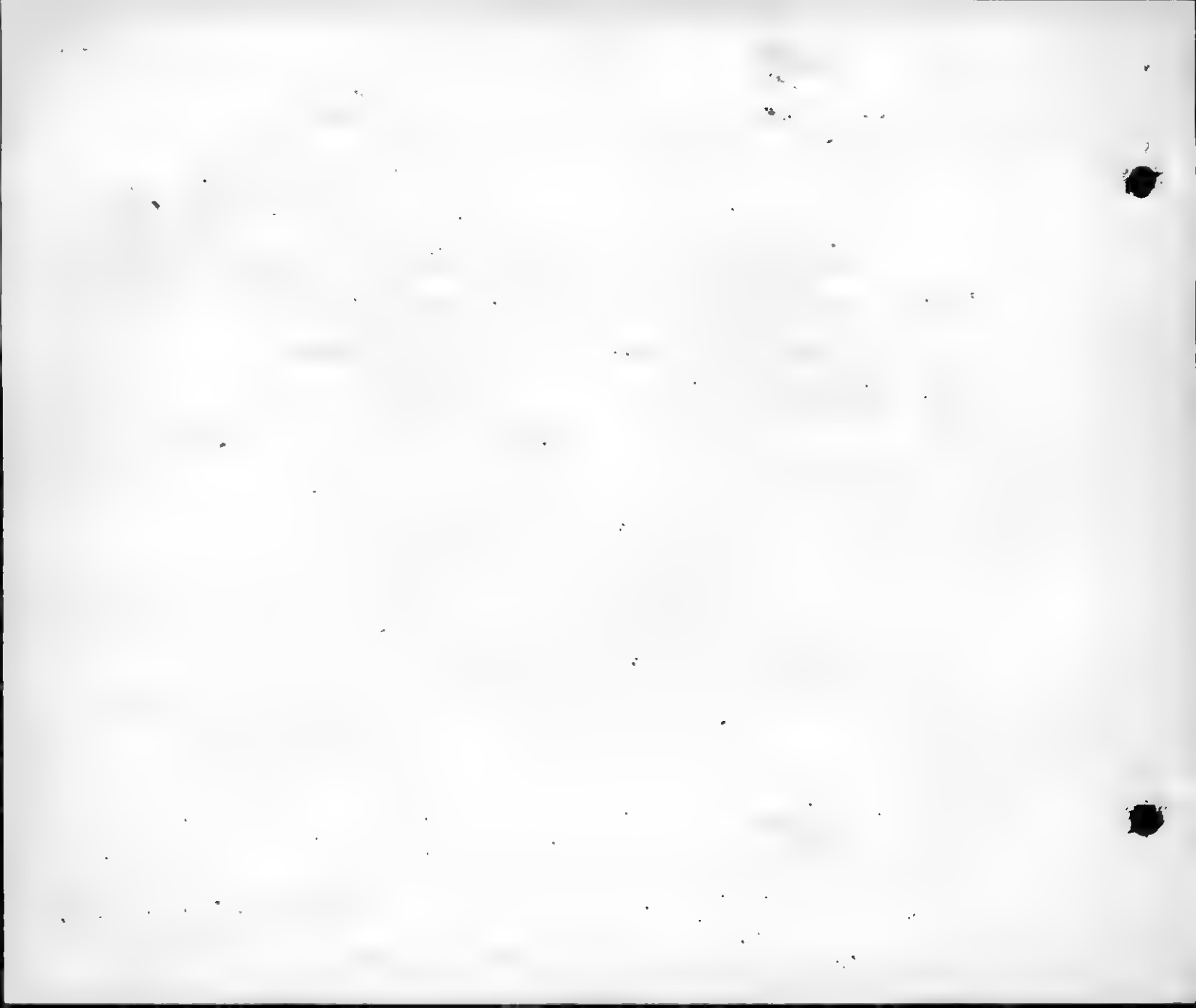
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>		d. STREET ADDRESS <i>2400 Willow Glen Dr</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Samuel Schwartz</i>		4. DATE OF DEATH Month Day Year <i>Dec. 14 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/26/1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	11. BIRTHPLACE (State or foreign country) <i>Rumania</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Jacob Schwartz</i>	
14. MOTHER'S MAIDEN NAME <i>Jennie ?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>100-100000</i>		INFORMANT <i>Elihu Schwartz</i> Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unenna - Apoplexy.</i> 350 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis CV Disease</i> DUE TO (c) <i>Parasitosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Atherosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1st 1957</i> to <i>Dec 14 1959</i> that I last saw the deceased alive on <i>Dec 14 1959</i> and that death occurred at <i>7:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. P. ...</i> M.D.		ADDRESS (Street, city or town, state) <i>3033 W. ...</i> DATE SIGNED <i>Dec 16 1959</i>	
PHYSICIAN'S NAME (Type) <i>M. P. ...</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/15/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Belair Young Men's</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Al. ...</i> ADDRESS <i>1124-26 W. ...</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>
DATE <i>DEC 18 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND—BALTIMORE, 18

It is to be filled out by the funeral director, 12/24/59 14k

13488

CERTIFICATE OF DEATH

Reg. Dist. No. 13466

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4312 Belvue Avenue 15. Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				d. STREET ADDRESS <u>Garrison Nursing Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Schwarzkopf</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>12</u> Min.		IF UNDER 24 HRS Months <u>9</u> Days <u>9</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Schwarzkopf</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Grove</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-07-7838</u>				17. INFORMANT <u>Mae W. Segerman-33 Dunkirk Rd. Balto. 12 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>4x10.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Dec 11, 1959</u> to <u>Dec 12, 1959</u> that I last saw the deceased alive on <u>Dec 12, 1959</u> and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>7501 York Rd. Baltimore, Md.</u>				DATE SIGNED <u>12/12/59</u>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell- M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, Inc. 1050 York Rd. Towson 4, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

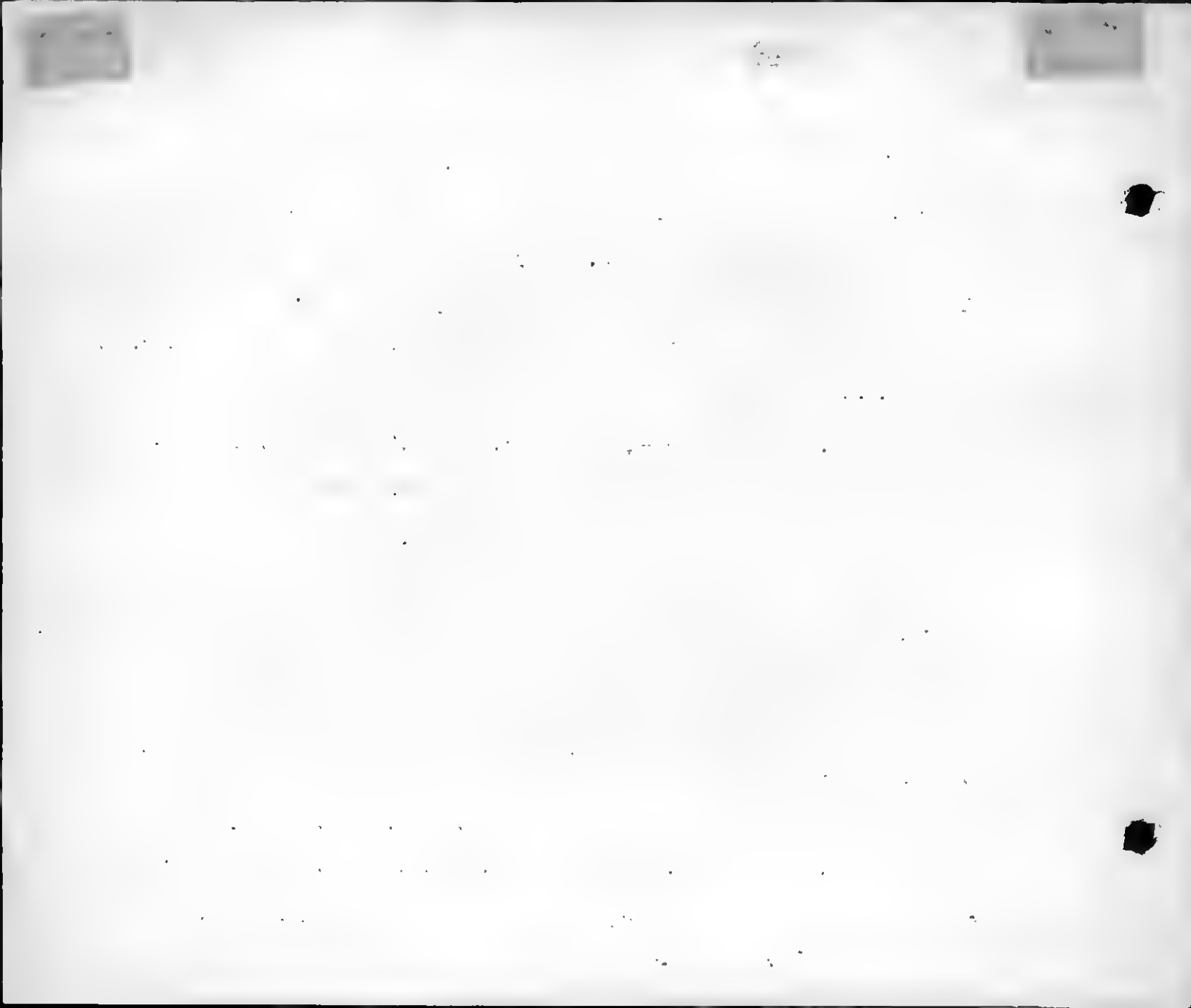
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. X 050 I 13489 13467 Reg. Dist. No. 4 13489 CERTIFICATE OF DEATH Reg. Dist. No. 4 13467 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 434 S. Oriole Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES W. SCOTT 4. DATE OF DEATH Month Day Year December 18 19 59 5 SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH April 18, 1890 9. AGE (In years last birthday) 69 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. 13. FATHER'S NAME Charles E. Scott 14. MOTHER'S MAIDEN NAME Nellie Creamer 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 216-01-4422 INFORMANT Address Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 449X THROMBOSIS OF ANTERIOR INFERIOR CEREBELLAR ARTERY INTERVAL BETWEEN ONSET AND DEATH 1 WEEK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE UNKNOWN (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d INJURY OCCURRED While ☐ of work Not while ☐ of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that VA attended the deceased from December 15, 1959 to December 18, 1959 and that death occurred at 2:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John W. Crawford M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 12/18/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD, DIVISION 12/18/59 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/22/59 22c. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery Baltimore, Maryland 22d LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schimunek Funeral Home - 3331 Brehms Lane 24a. REC'D BY REGISTRAR DATE DEC 22 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13490

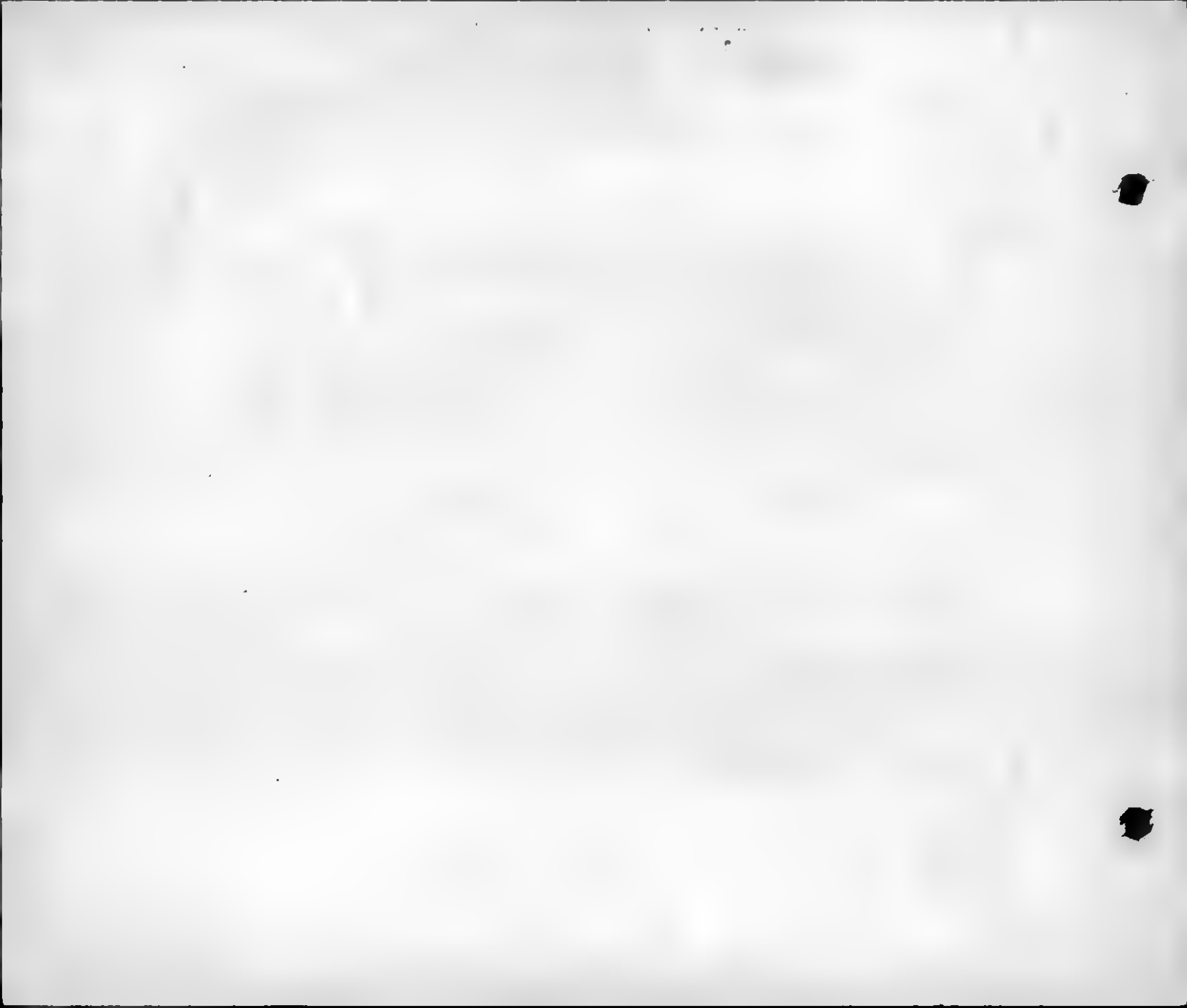
CERTIFICATE OF DEATH

Reg. Dist. No.

13468

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonleigh, Baltimore</u>	
c. LENGTH OF STAY IN Yr <u>12</u>		d. STREET ADDRESS <u>1910 Overbrook Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>910 Overbrook Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs E Dittz Scott</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Samuel Eppler</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Elgen Fritz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Edythe Harrison</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Recent)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>Coronary Sclerosis Disruptive</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Myocardial Infarction - Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2006-19-1959</u> to <u>Dec 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>59</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Walter A. Anderson</u> M.D. <u>3001 Sherman Blvd</u> INTERVIEWER'S NAME (Type) <u>WALTER A. ANDERSON</u> <u>Beth B. Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Marysville PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Lee</u> ADDRESS <u>5209 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13334

CERTIFICATE OF DEATH

Reg. Dist. No.

13469

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3500 Louth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA First Middle Last SEABURY		4. DATE DEATH December 25, 19 59 Month Day Year	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Leverich		14. MOTHER'S MAIDEN NAME Sarah Sniffen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO INFORMANT Address Mrs. Madeline S. Mead, 3500 Louth Road-22	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 years (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that I attended the deceased from 12-25-1959 to 12-25-1959 , that I last saw the deceased alive on 12-25-1959 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE See David		DATE SIGNED 12-26-59	
PHYSICIAN'S NAME (Type) B.W. SALLAD, M.D.		ADDRESS (Street, city or town, state) Dundalk-22-Ind	
21a. BURIAL CREMATION, REMOVAL (Specify) Burial	21b. DATE THEREOF 12/26/50	21c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery	
21d. LOCATION (City, town, or county) (State) Peekskill, N.Y.		21e. REC'D BY REGISTRAR DEC 30 '59	
21f. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		21g. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

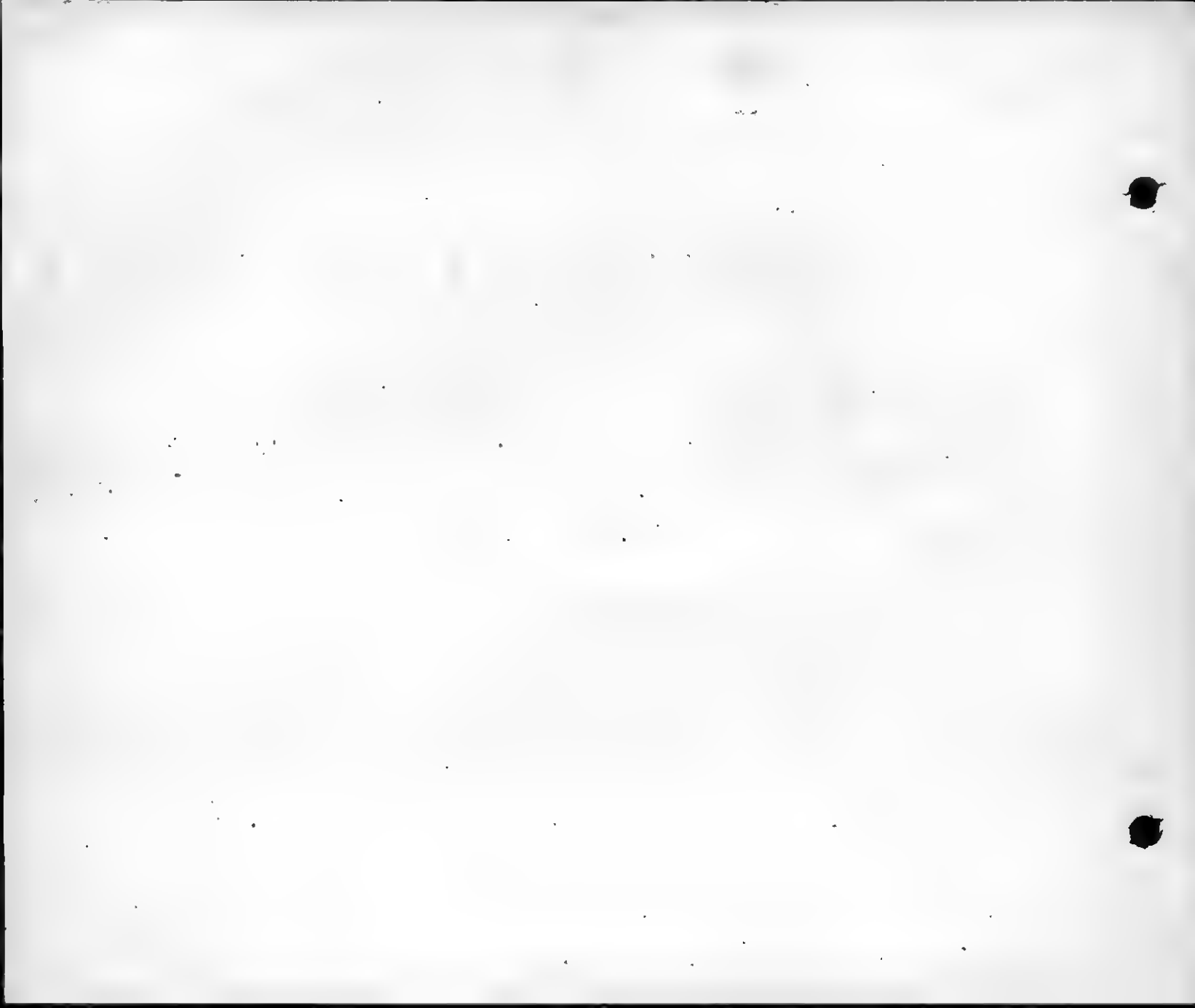
CERTIFICATE OF DEATH

Reg. Dist. No.

13491

13470

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11420 Reisterstown Road				e. STREET ADDRESS 11420 Reisterstown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle C. W. Last SEIM				4. DATE OF DEATH Month Dec. Day 18 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1874	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Frederick Wehrenberg				14. MOTHER'S MAIDEN NAME Minnie Suchting			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. J. Fred Ningard-11420 Reisterstown Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute DUE TO Intussusception Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Intussusception DUE TO (c) Intussusception INTERVAL BETWEEN ONSET AND DEATH Minutes 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 19, 1959 to Dec 18, 1959 that I last saw the deceased alive on Dec 5, 1959 , and that death occurred at 11:42 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE DIED Dec 18, 1959							
ACTUAL SIGNATURE William S. Williams M.D. Reisterstown, Maryland							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Violetville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tischer & Sons Baltimore, Md.				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Brown	



CERTIFICATE OF DEATH

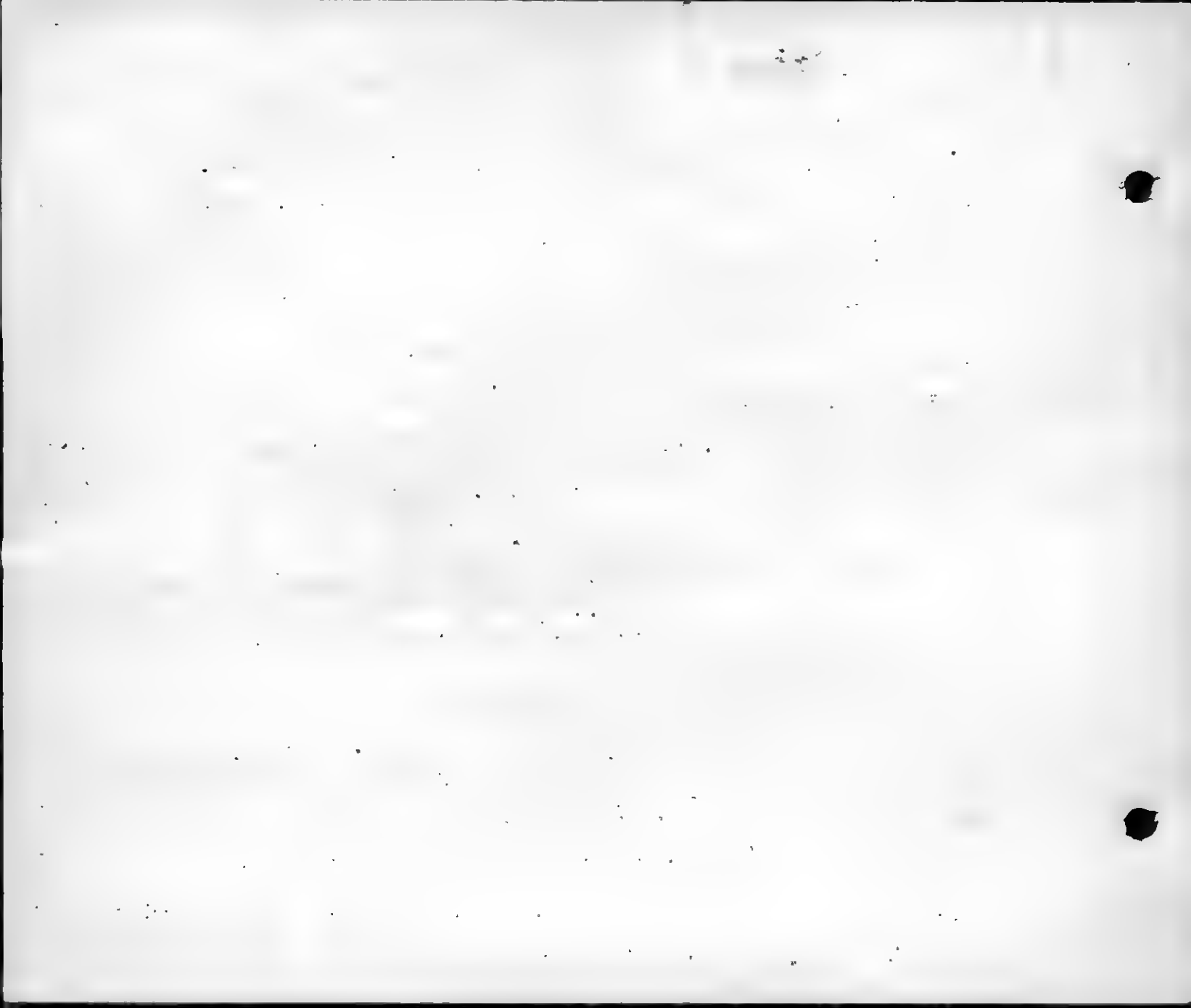
Reg. Dist. No.

13492

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 137 N KENWOOD AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9305 PHILA RD #6				d. STREET ADDRESS 137 N KENWOOD AVE.			
3. NAME OF DECEASED (Type or print) DAISY First V Middle S Last SELTZER				4. DATE OF DEATH Month DEC Day 20 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 17, 1878	
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES K SELTZER				14. MOTHER'S MAIDEN NAME MATHILDA. HOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		INFORMANT MRS HEURY J HOFFMEISTER		Address 9305 PHILA RD #6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intestinal Obstruction (c) Carcinoma - uterus Arteriosclerosis generalized						INTERVAL BETWEEN ONSET AND DEATH 2 days ? !	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) arthritis - generalized						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 1.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1, 1958 to Dec. 20, 1959 that I last saw the deceased alive on Dec. 20, 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis F. Klimes M.D.				ADDRESS (Street, city or town, state) 2623 E. Monument St. BALTO. M.D.			
PHYSICIAN'S NAME (Type) LOUIS F. KLIMES M.D.				DATE SIGNED 12/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/59		22c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		22d. LOCATION (City, town, or county) (State) BALTO MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Jessie Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE DEC 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13472

13493

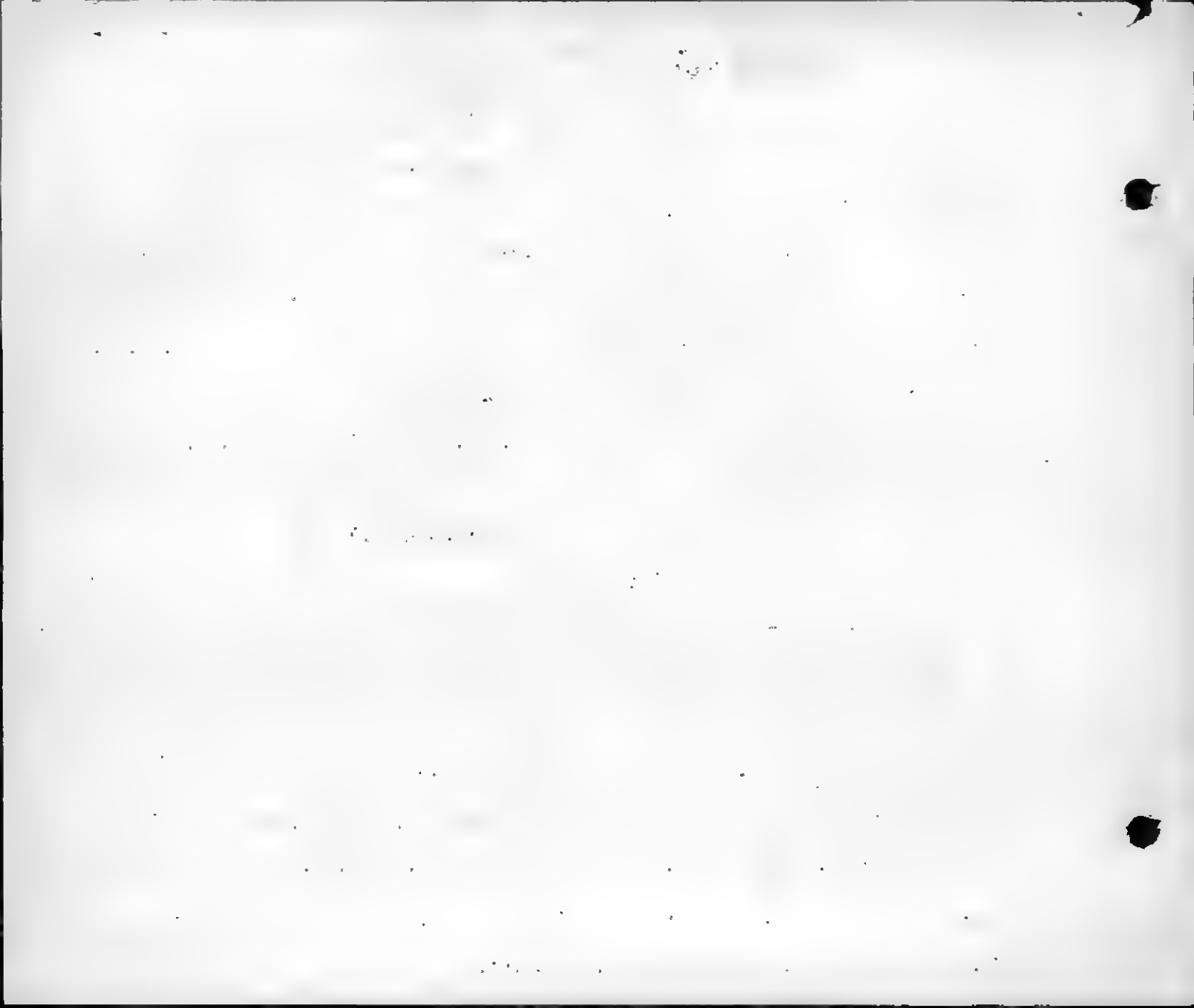
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7004 Marietta Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last NICK --- SENANES			4. DATE OF DEATH Month Day Year December 2 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1888		9. AGE (In years last birthday) yrs. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor-Owner		10b. KIND OF BUSINESS OR INDUSTRY Lunch Room	11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Paul Senanes			14. MOTHER'S MAIDEN NAME Helen Fatorea		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-09-4335	INFORMANT Address Clin. Rec. VAH, Baltimore 18, Md. Ft. Howard Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CONDITIONS, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (b) CEREBRAL THROMBOSIS DUE TO (c) RECENT					INTERVAL BETWEEN ONSET AND DEATH 1 HOUR UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS- Duration Unknown					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
21. I certify that I attended the deceased from November 28 1959 to December 2 1959 , and that death occurred at 1:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD. FT. HOWARD DIVISION 12/2/59 ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION 12/2/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto, Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

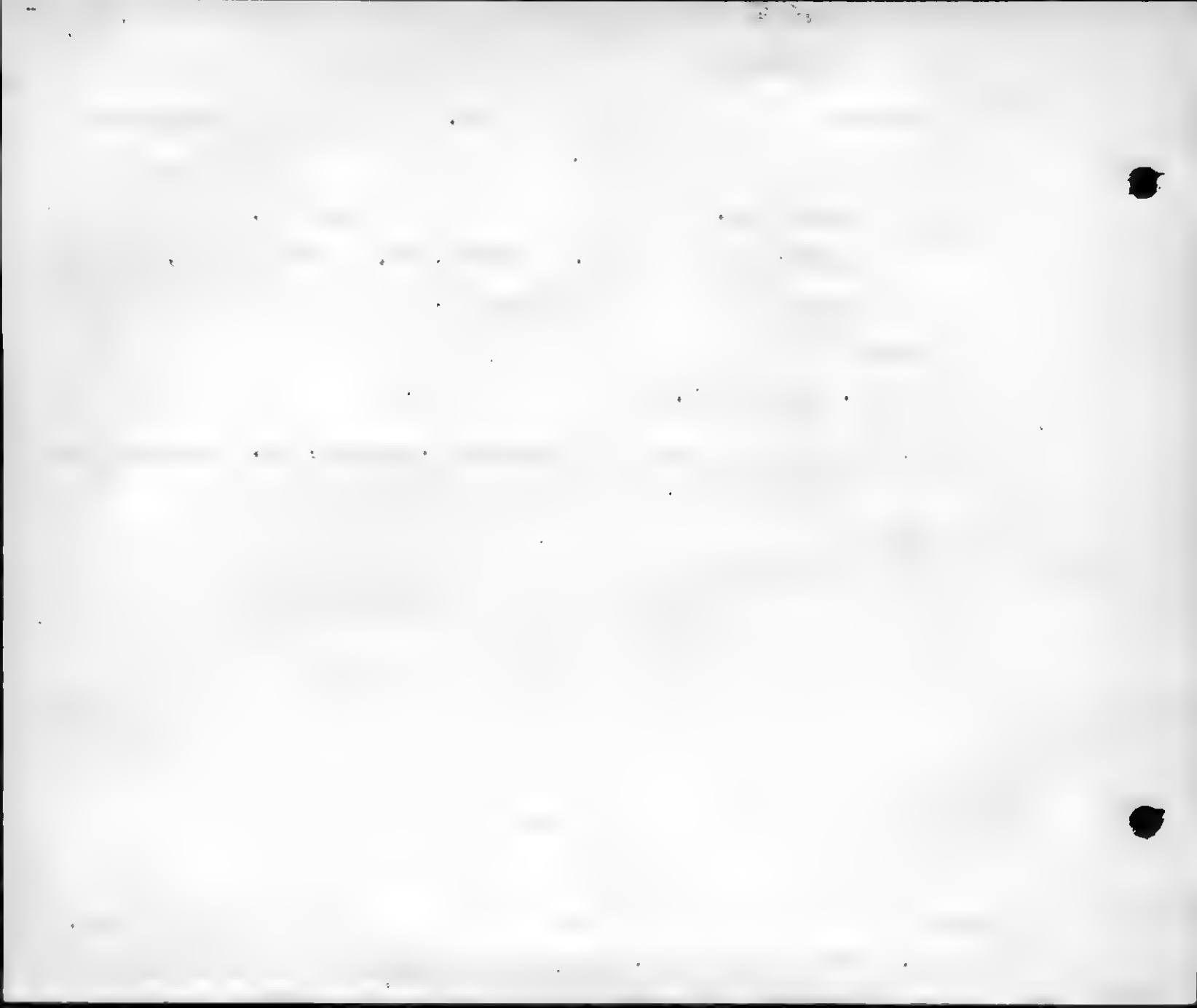


13494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood				c. LENGTH OF STAY IN lb 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8212 Bellona Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle N. Last Sewell, Jr.				4. DATE OF DEATH Month December Day 3 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1950	
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph N. Sewell, Sr.				14. MOTHER'S MAIDEN NAME Rose Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Joseph N. Sewell, Sr. (Above)			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3 Congestive Heart Failure DUE TO (b) Chronic Bronchopneumonia 3wPs. DUE TO (c) Fibrocystic Disease of Pancreas Birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/4 , 19 55 , to 12/3 , 19 59 ; that I last saw the deceased alive on 12/3 , 19 59 , and that death occurred at 9:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Niermann M.D.				ADDRESS (Street, city or town, state) 6229 N. Charles St. DATE SIGNED			
PHYSICIAN'S NAME (Type) WM. A. NIERMANN				Baltimore 12, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Parkville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co.				ADDRESS 4905 York Rd Baltimore 12, Md.		24a. REC'D BY REGISTRAR DEC 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13474

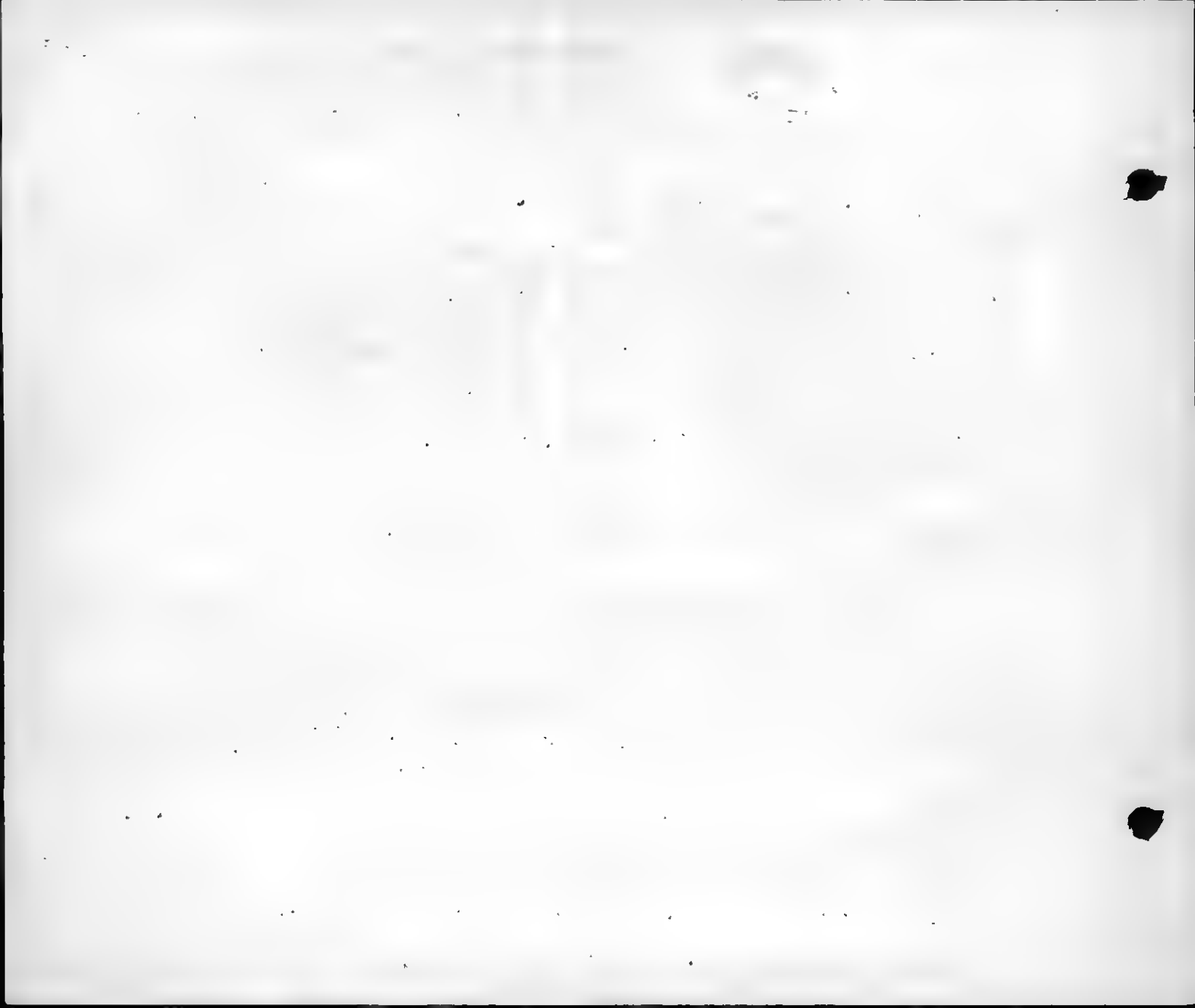
13495

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b 35 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 913 ESSEX AVE. #21 MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES M. SHAFFER				4. DATE OF DEATH Month Day Year DEC 26 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 5, 1887	
9. AGE (In years lost birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER				10b. KIND OF BUSINESS OR INDUSTRY BETHLEH. STEEL		11. BIRTHPLACE (State or foreign country) YORK PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE B SHAFFER				14. MOTHER'S MAIDEN NAME LYDIA KOOLITZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. 1		17. INFORMANT Address MRS CHARLS M. SHAFFER. 913 ESSEX AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Hypertensive Arterio-sclerotic Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inguinal hernia left							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore		20f. (City or town) (County) (State) 21 Maryland	
21. I certify that I attended the deceased from Oct 9, 1958 , to Dec. 18, 1959 , that I last saw the deceased alive on December 24, 1959 , and that death occurred at 3:04 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Manuel P. de Leon		M.D. Dec. 26, 1959		ADDRESS (Street, city or town, state) 1840 Eastern Ave - Balt. 24, 1959		DATE SIGNED 12/26/59	
PHYSICIAN'S NAME (Type) MANUEL P DE LEON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 29, 1959		22c. NAME OF CEMETERY OR CREMATORY MT PROSPECT CEM.		22d. LOCATION (City, town, or county) (State) SEVEN VALLEYS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Lashin Funeral Home		ADDRESS 7401 BELAIR ROAD		24a. REC'D BY REGISTRAR #6		24b. REGISTRAR'S SIGNATURE Charles E. K...	
				DATE DEC 29 '59			

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13475

Reg. Dist. No.

13495

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>47 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton,</u>		d. STREET ADDRESS <u>Rayville Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rayville Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmer Ellsworth Shaver, Jr.</u>				4. DATE OF DEATH Month Day Year <u>Dec. 31 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26 1912</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>E. E. Shaver, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Wilson.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mary S. Shaver, Parkton, Md. R. D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot gun wound of the head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself in the head with a 12 gauge shotgun</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:30 a.m. Dec. 31 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Parkton, Baltimore, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>A. M. France</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial Jan. 2, 1960</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13497

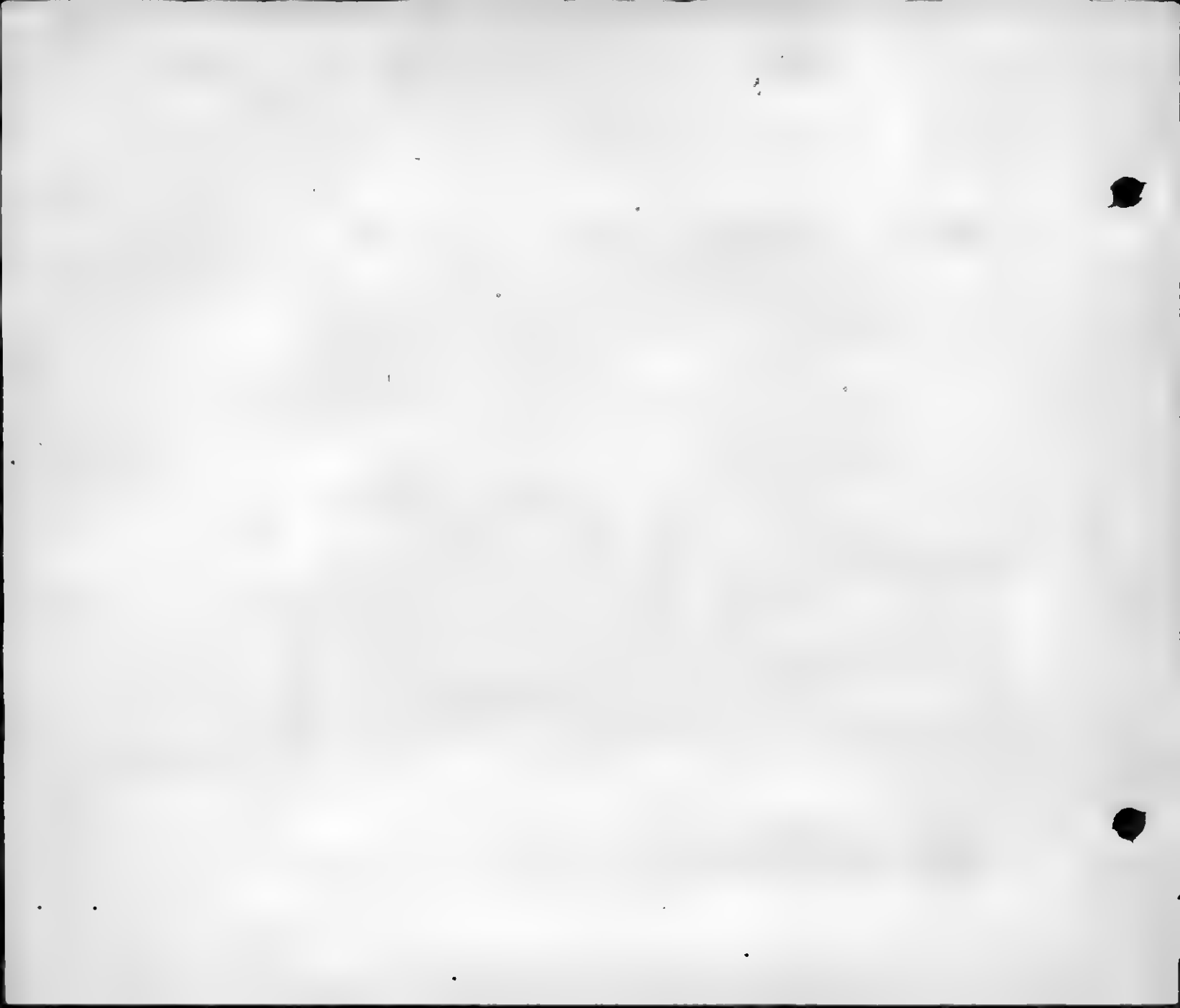
CERTIFICATE OF DEATH

13476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hyde		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyde	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Merryland Farms-Hyde, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel (Danny) O.C. Shea		4. DATE OF DEATH Month December Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1897
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR: Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Breeder		10b. KIND OF BUSINESS OR INDUSTRY Horse Breeding	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Shea		14. MOTHER'S MAIDEN NAME Mary O'Connell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Wwland Wwll	
17. INFORMANT Elizabeth W. Shea-Merryland Farms, Hyde, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 1957 to present , that I last saw the deceased alive on December 10, 1959 , and that death occurred at 401 Medical Arts Bldg , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Medical Arts Bldg DATE SIGNED 12-15-59			
ACTUAL SIGNATURE John Russell Davis		PHYSICIAN'S NAME (Type) John Russell Davis	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/18/59	22c. NAME OF CEMETERY OR CREMATORY St. John's	22d. LOCATION (City, town, or county) (State) Long Green Pike, Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		24a. REC'D BY REGISTRAR DEC 17 '59 24b. REGISTRAR'S SIGNATURE C. L. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

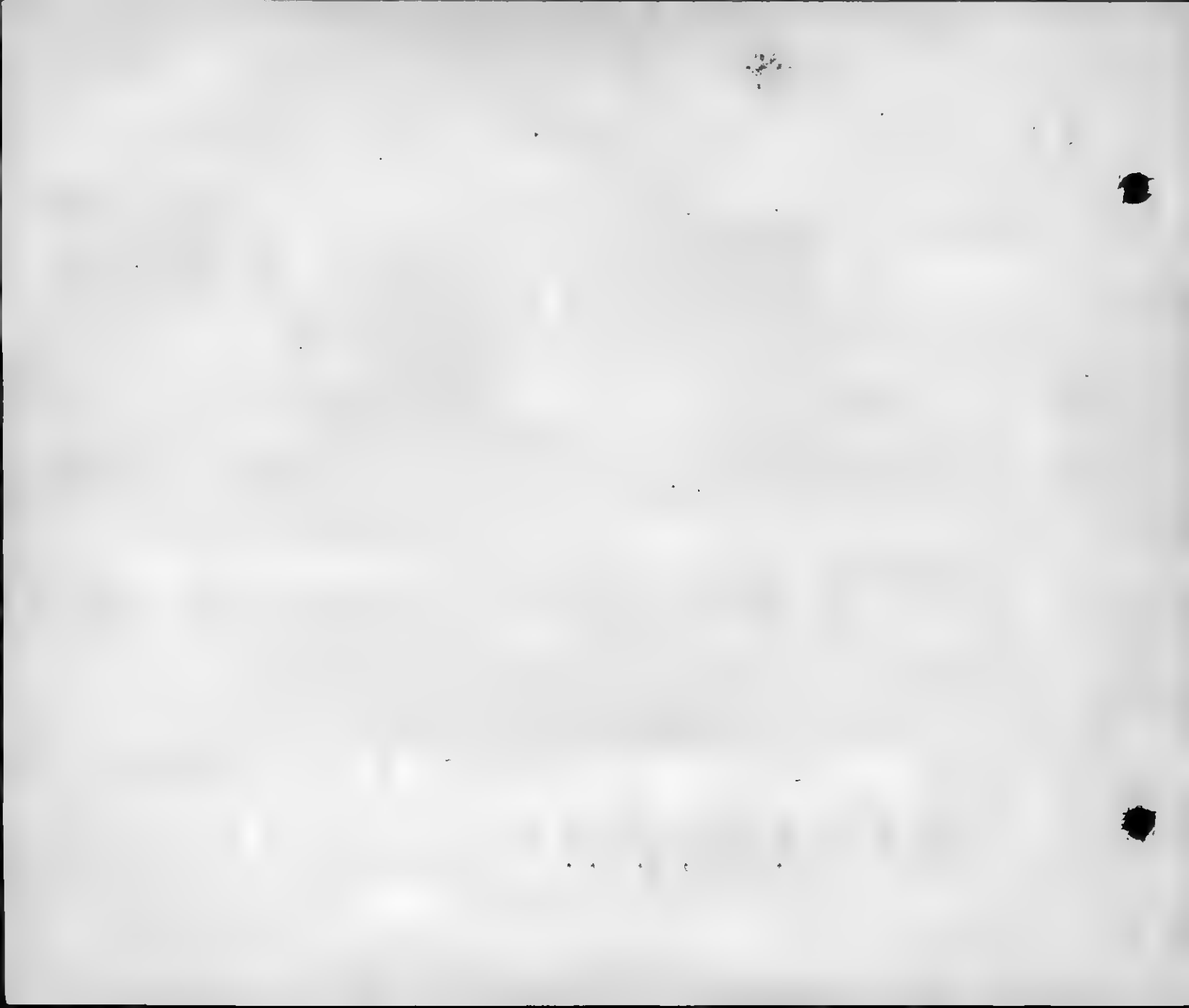


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-
neal the certificates, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13477

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6803 Greenspring Avenue		d. STREET ADDRESS 6803 Greenspring Avenue	
3. NAME OF DECEASED (Type or print) SCOTT		4. DATE OF DEATH December 18, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-29-1959
9. AGE (In years last birthday) 1 yrs. 21 Months 21 Days		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Silvers		14. MOTHER'S MAIDEN NAME Lucille LeCompte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Silvers - same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/18/59	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 12-20-59	22c. NAME OF CEMETERY OR CREMATORY Oak Hill	22d. LOCATION (City, town, or country) (State) Baltimore Md
23. FUNERAL DIRECTOR Jack Lewis Inc 2100 Eutan Place		24. REC'D BY REGISTRAR DATE DEC 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13499

CERTIFICATE OF DEATH

Reg. Dist. No.

13478

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd</u>				d. STREET ADDRESS <u>Belair Rd. Fullerton PO.</u>			
3. NAME OF DECEASED (Type or print) <u>Lester Benjamin Simms</u> First Middle Last				4. DATE OF DEATH <u>Dec. 12</u> Month Day Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18th 1923</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paving</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas. E. Simms</u>				14. MOTHER'S MAIDEN NAME <u>Hattie M. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-742</u>		17. INFORMANT <u>Mrs. Lester Simms</u> Address <u>Belair Rd Fullerton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour s. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 1957, to <u>Dec.</u> , 1959, that I last saw the deceased alive on <u>Dec. 12</u> , 1959, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. <u>Kingsville, Md.</u>				DATE SIGNED <u>12-13-59</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larson Funeral Home</u> ADDRESS <u>4401 Belair Rd</u>				24a. REC'D BY REGISTRAR <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. E. Tyson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13500

CERTIFICATE OF DEATH

13479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALDWIN</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LONG GREEN PIKE</u>				e. STREET ADDRESS <u>LONG GREEN PIKE</u>			
3. NAME OF DECEASED (Type or print) <u>BARBARA R SIMS</u>				4. DATE OF DEATH Month <u>12</u> Day <u>-16</u> Year <u>-1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN MAST</u>				14. MOTHER'S MAIDEN NAME <u>MELINDA BEERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN E. SIMS</u> Address <u>BALDWIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month <u>12</u> Day <u>16</u> Year <u>1959</u> Hour <u>o. m.</u> <u>p. m.</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>Dec 16, 1959</u> to <u>Dec 16, 1959</u> that I last saw the deceased alive on <u>Dec 16, 1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter M. Hammett</u> M.D.				ADDRESS (Street, city or town, state) <u>BALDWIN MD</u>			
PHYSICIAN'S NAME (Type) <u>Walter M. Hammett</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) <u>LONG GREEN MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS, SON</u> ADDRESS <u>8802 HARTFORD RD</u>				24a. REC'D BY REGISTRAR <u>DEC 21 '59</u> DATE <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

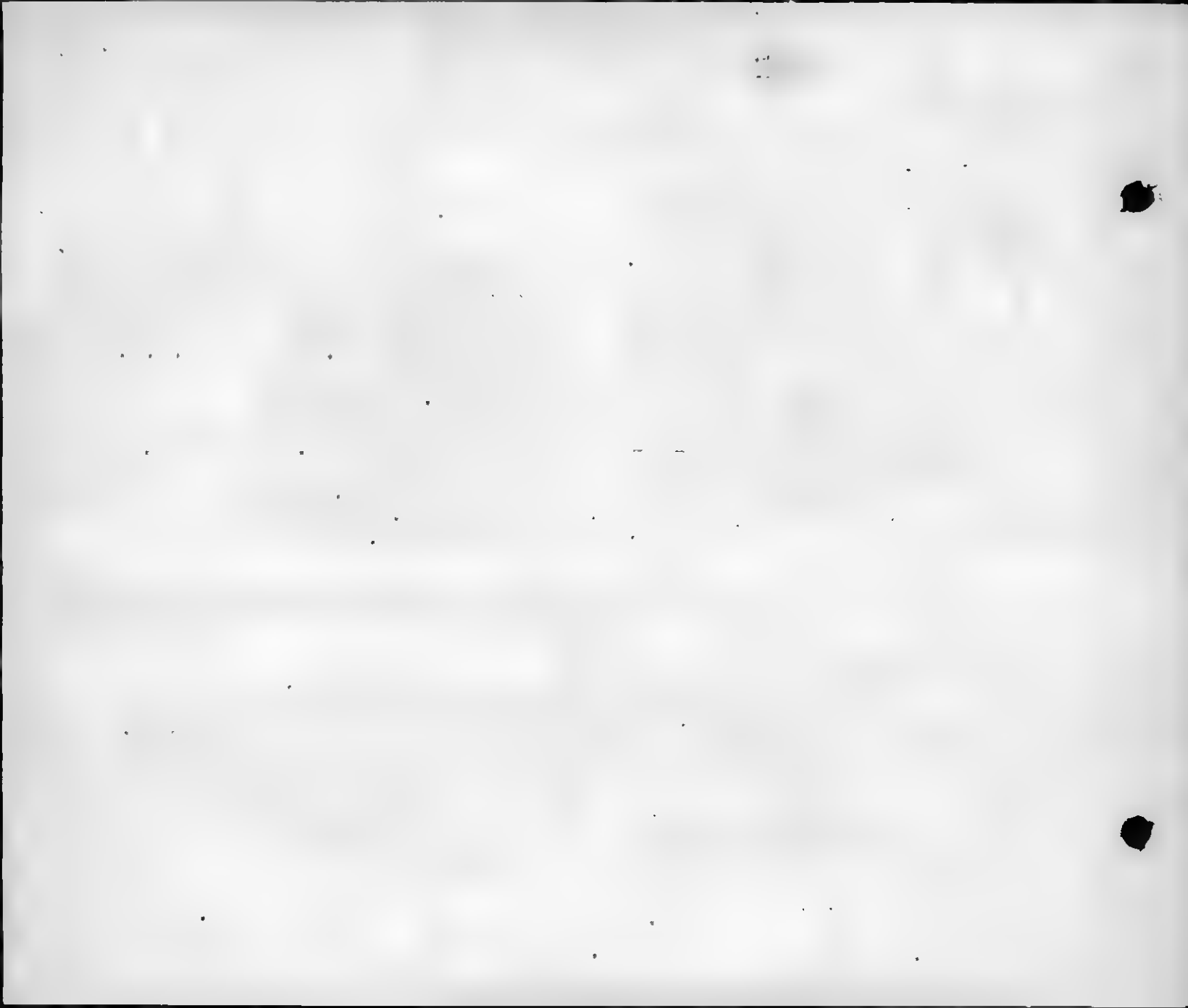
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Company Dispensary				d. STREET ADDRESS 402 S. Bonsal Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First Harry Middle J. Last SKRUCH		4. DATE OF DEATH Month 12 Day 31 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/1917		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pit foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josrph Skruch				14. MOTHER'S MAIDEN NAME Mary C. Baranowska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-3942		17. INFORMANT Address Agnes Skruch 402 S. Bonsal St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury and burn (4th deg.) of lower portion of right side of body. Traumatic amputation and burn of left arm. DUE TO (b) Crushing injury and burn (4th deg.) of lower portion of right side of body. Traumatic amputation and burn of left arm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ingot buggy toppled over onto deceased.							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingot buggy toppled over onto deceased.					
20c. TIME OF INJURY Month, Day, Year 5:15 AM 12/31/59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Steel Mill		20f. (City or town) (County) (State) Sparrows Point, Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/31/59			
EXAMINER'S NAME (Type) M B Davis		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/1960		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John M. Weber & Sons Inc 401 S. Chestern St				24a. REC'D BY REGISTRAR DAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13502

CERTIFICATE OF DEATH

Reg. Dist. No.

13481

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b 3 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6631 Dogwood Rd.				d. STREET ADDRESS 6631 Dogwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alice Middle L. Last Slattery				4. DATE OF DEATH Month Dec. Day 4 Year 1959.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20-1876	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Hildibrand				14. MOTHER'S MAIDEN NAME Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Wm. Slattery (Son) Sulpnur Spring Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X DUE TO cerebral aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/28 , 19 59 , to 12/4 , 19 59 , that I last saw the deceased alive on 11/28 , 19 59 , and that death occurred at 6 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED 12-5-59			
PHYSICIAN'S NAME (Type) WILLIAM L. L. L.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7-1959.		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS 5646 Carville Ave.		24b. REGISTRAR'S SIGNATURE [Signature]	
24a. REC'D BY REGISTRAR DATE DEC 8 '59							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Academy Avenue		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS Academy Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CATHERINE VIRGINIA SMITH 4. DATE OF DEATH December 9 1959		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 14, 1919 9. AGE (In years last birthday) 40 yrs IF UNDER 1 YEAR: Months 40 Days 40 IF UNDER 24 HRS. Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence Robenson		14. MOTHER'S MAIDEN NAME Louise Latlief	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-20-7536 17. INFORMANT John W. Smith Address Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 525X DUE TO Interstitial pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 525X DUE TO Interstitial pneumonitis (c) 525X DUE TO Interstitial pneumonitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 525X DUE TO Interstitial pneumonitis		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 59 22c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery 22d. LOCATION (City, town, or country) (State) Clarksville Md.	
23. FUNERAL DIRECTOR J.F. Eline & Sons ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DEC 11 '59 24b. REGISTRAR'S SIGNATURE Orlinda L. Howard	



13504

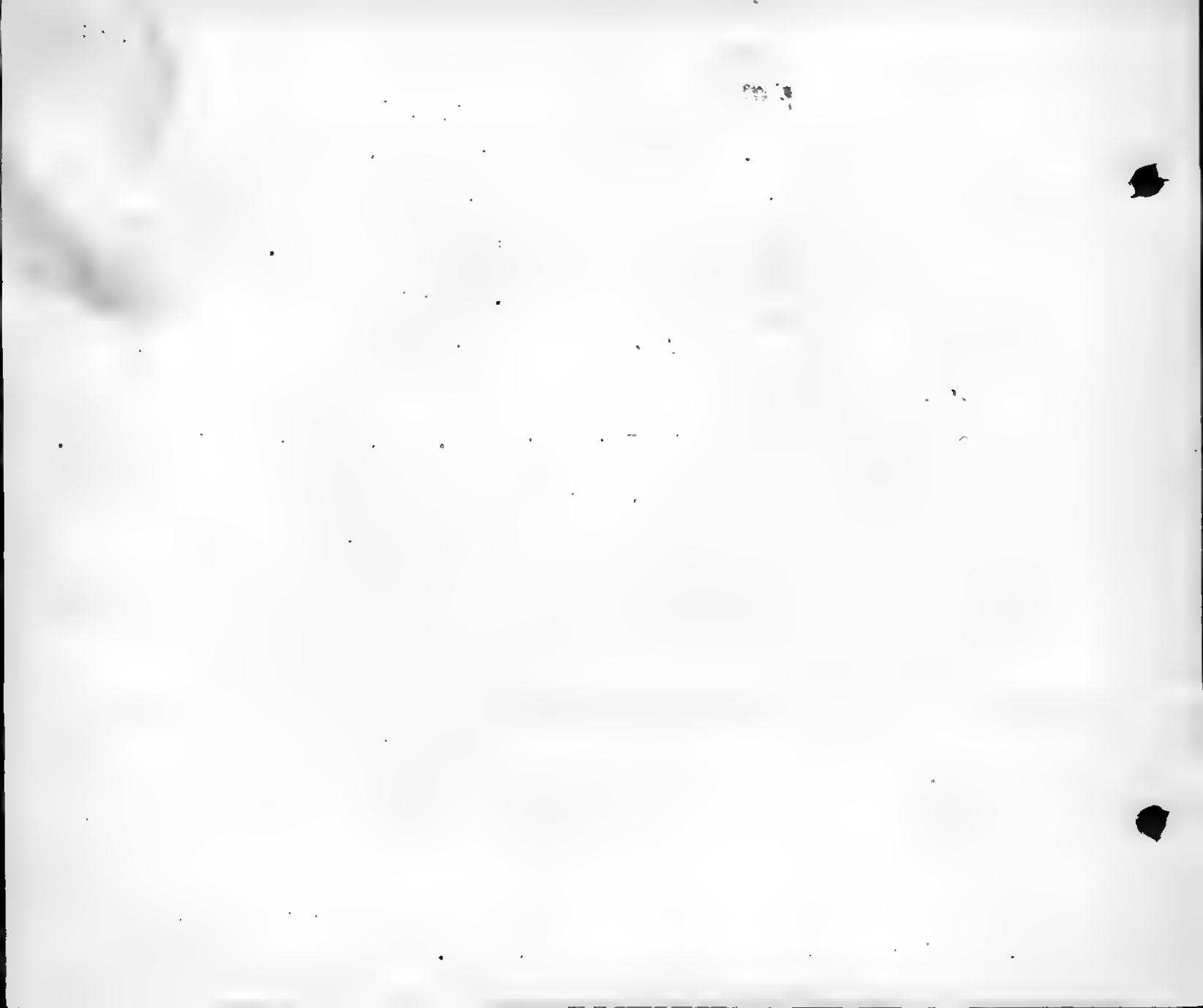
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Green Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle SMITH Last SMITH		4. DATE OF DEATH Month Dec. Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	11. IF UNDER 24 HRS Months 82 Days 82 Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad C. Smith		14. MOTHER'S MAIDEN NAME Caroline Ledder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-5951	
INFORMANT Address Augusta B. Smith-Green Rd. Baldwin, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Infarction 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Small Artery (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1930 to 1959 , that I last saw the deceased alive on Dec 21, 1959 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1425-34 SIGNED ACTUAL SIGNATURE Hatter M. Hammon M.D. Baldwin PHYSICIAN'S NAME (Type) Hatter M. Hammon Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd. Towson 4, Md		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13484

Reg. Dist. No.

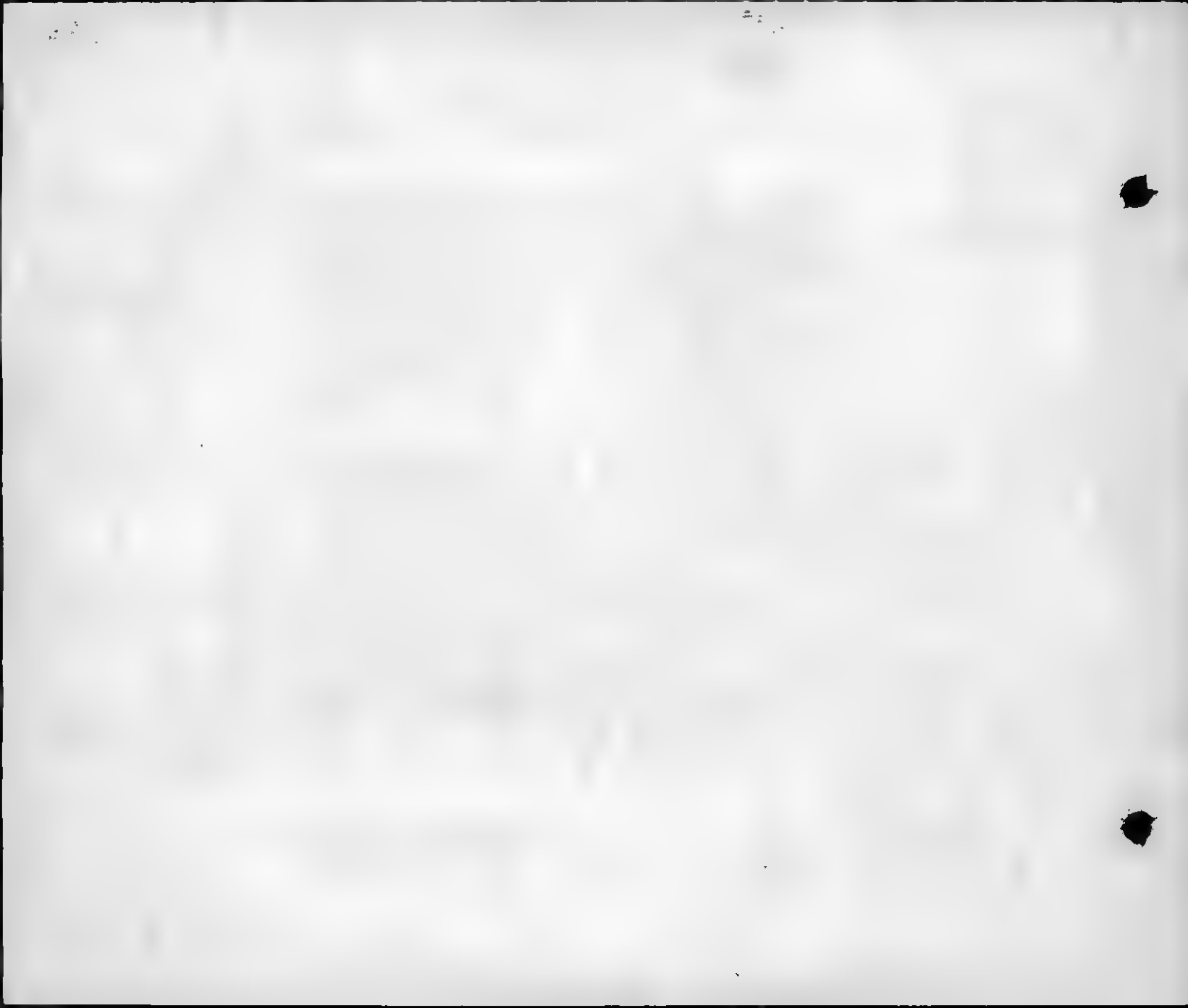
13503

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>401 JEFFERSON AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD LORRAINE SMITH</u>				4. DATE OF DEATH Month Day Year <u>12/26/59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1906</u>	9. AGE (In years last birthday) <u>53</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAS. H. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>CLARA WATKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216 014198</u>		17. INFORMANT Address <u>ALICE CHEVER-2813 PRESBURY ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>12/26/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/27/59</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Blum</u>				ADDRESS <u>1701 Michigan St. Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13506

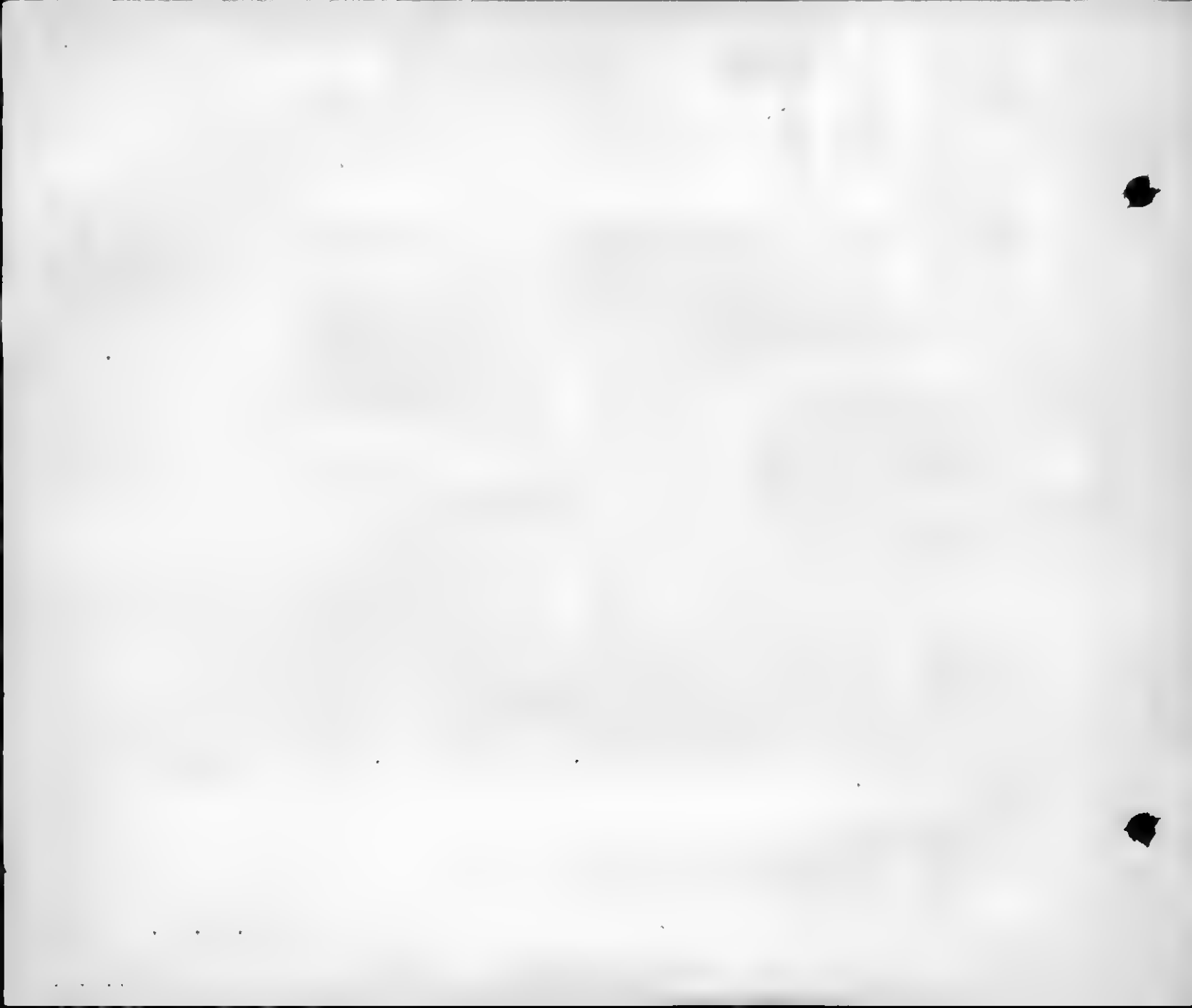
CERTIFICATE OF DEATH

13485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr5mths	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Robert Last Somers		4. DATE OF DEATH Month December Day 19 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1912
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR: Months 46 Days 46 Hours 46 Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stove assembler		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Somers		14. MOTHER'S MAIDEN NAME Agnes Kinney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mental Disease (Schizophrenia) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH months years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 17, 1959 , to Dec. 19, 1959 , that I last saw the deceased alive on Dec. 19, 1959 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radalska M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12/19/59	
PHYSICIAN'S NAME (Type) BRUNO RADALSKA		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/23/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE She S. H. Jones Co		ADDRESS 2901-14th St N.W.	
24a. REC'D BY REGISTRAR DEC 23 1959		24b. REGISTRAR'S SIGNATURE Charles E. H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

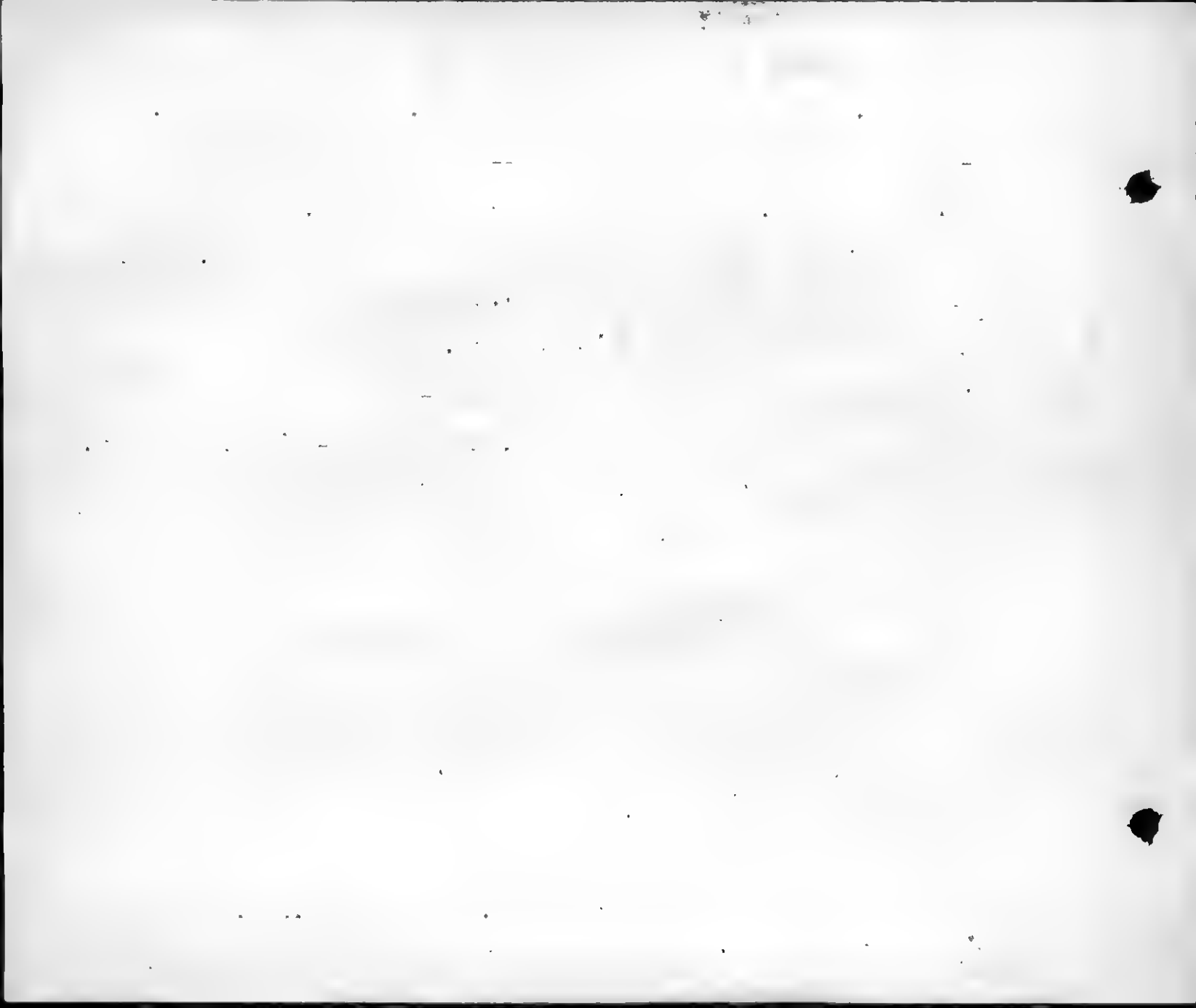
13486

13507

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3621 Patterson Ave.		e. STREET ADDRESS 3621 Patterson Ave.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SORRELL Last SORRELL		4. DATE OF DEATH Month Dec. Day 12 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd		10b. KIND OF BUSINESS OR INDUSTRY Monitor Controller	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Sorrell		14. MOTHER'S MAIDEN NAME Annie -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Margaret Keen - 3621 Patterson Ave. #7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO with congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hernia INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 March, 1954 to 12 Dec, 1959 that I last saw the deceased alive on 19 Dec, 1959 , and that death occurred at 9:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARVIN H. DAVIS, M. D. DATE SIGNED 6512 Liberty Road Baltimore 7, Md.			
ACTUAL SIGNATURE Marvin H. Davis		M.D. 6512 Liberty Road Baltimore 7, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lohrman & Son - Balto		24a. REC'D BY REGISTRAR DATE DEC 15 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE C. L. Keen	

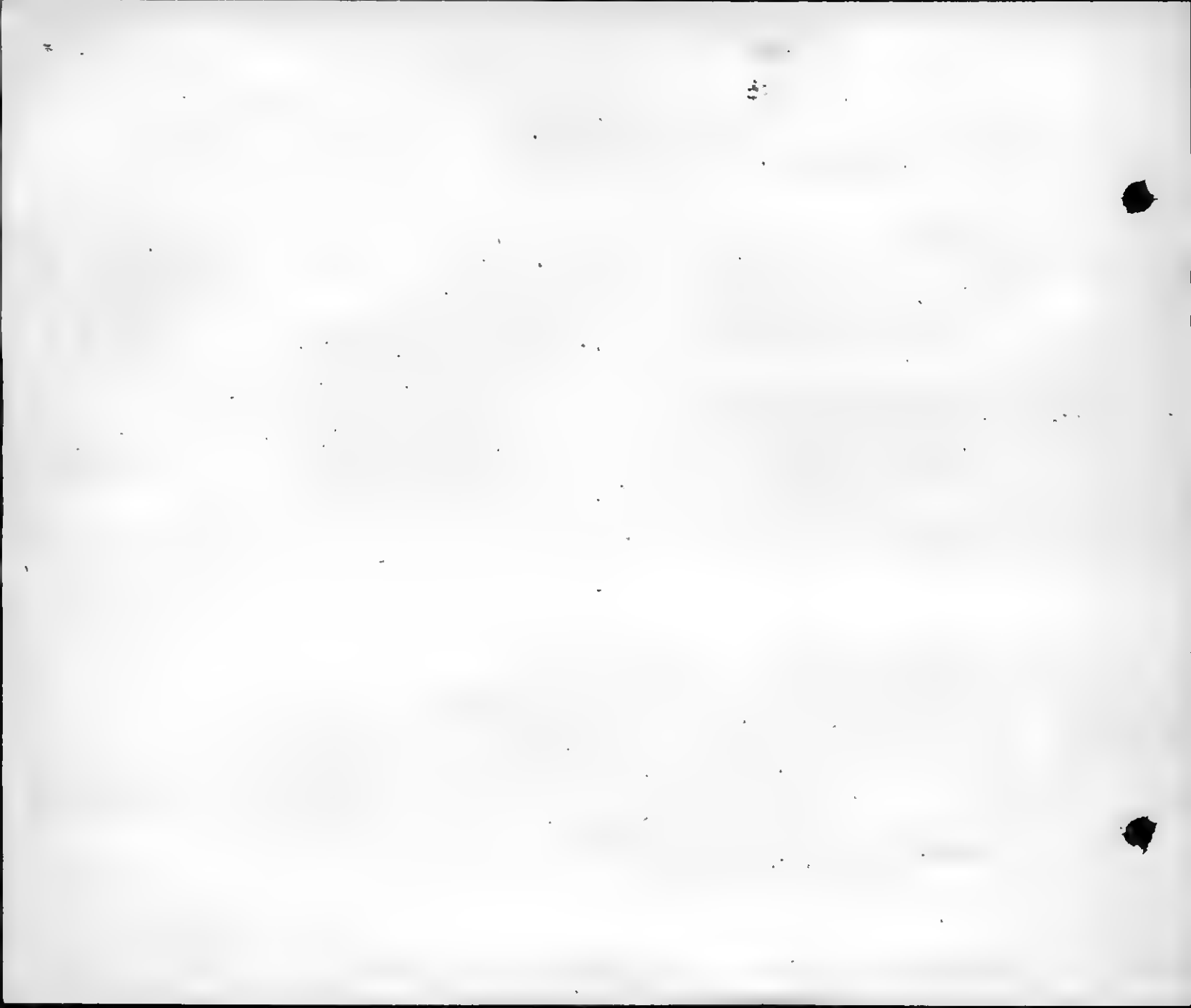
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



24b. REGISTRAR'S SIGNATURE

VS A15 (4)
15M 9/58



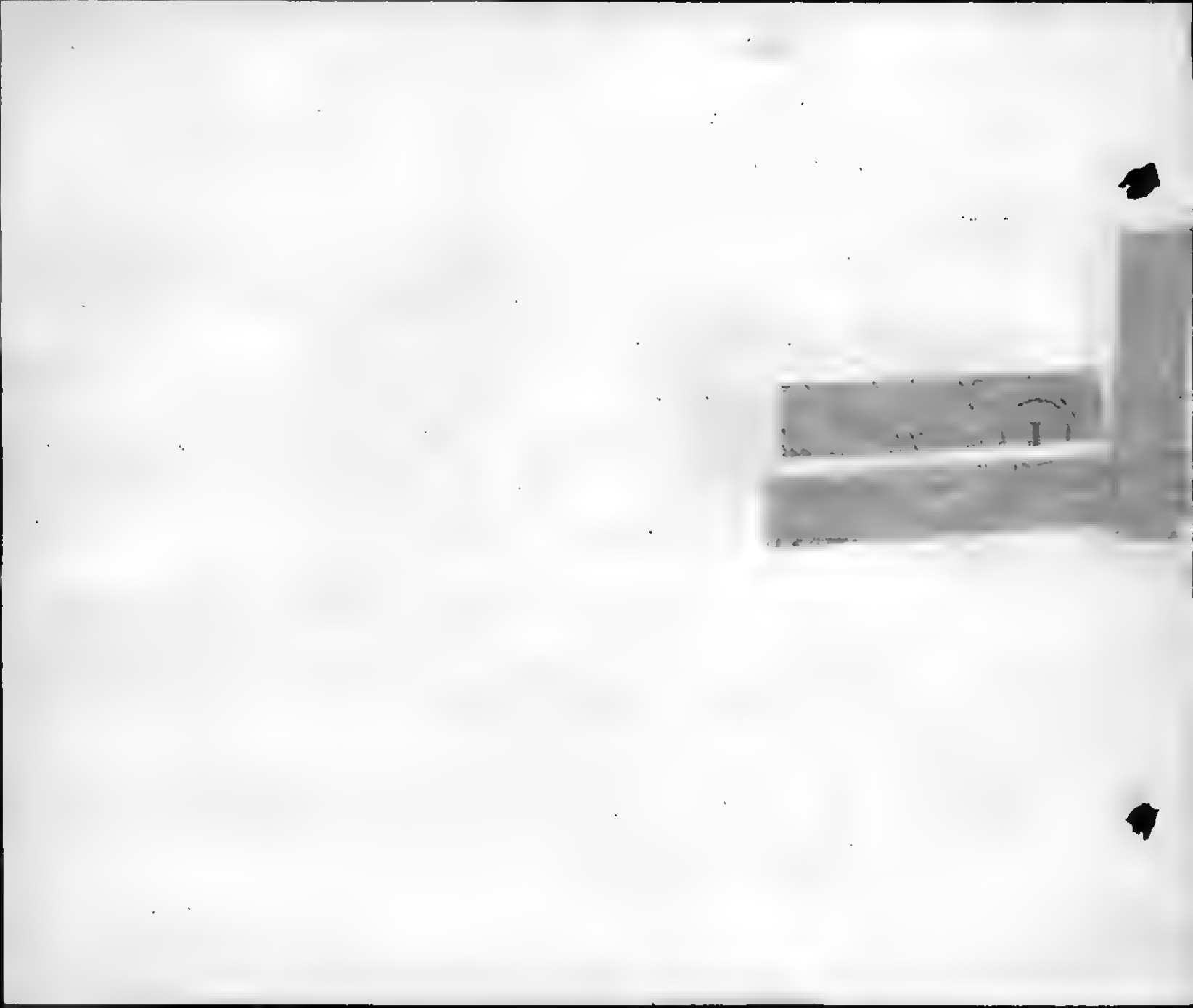
13509

CERTIFICATE OF DEATH

Reg. Dist. No.

13488

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Latonsville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Upperco Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor-Mrs. Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR - N - STANSBURY</u>		4. DATE OF DEATH Month Day Year <u>Dec 25 1959</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 - 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.S.A.</u>	
13. FATHER'S NAME <u>Nelson Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Abby Brummell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-441</u>	
17. INFORMANT <u>John Pindell - Upperco Rd. Ind</u>		Address	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> DUE TO (b) <u>Cardio-Vascular Disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11:45</u> to <u>12:45</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edgar E. Urban</u>		ADDRESS (Street, city or town, state) <u>805 Srd. Ave 28th</u>	
PHYSICIAN'S NAME (Type) <u>Edgar E. Urban</u>		DATE SIGNED <u>12-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown-Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Urban</u>		24a. REC'D BY REGISTRAR <u>DEC 29 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

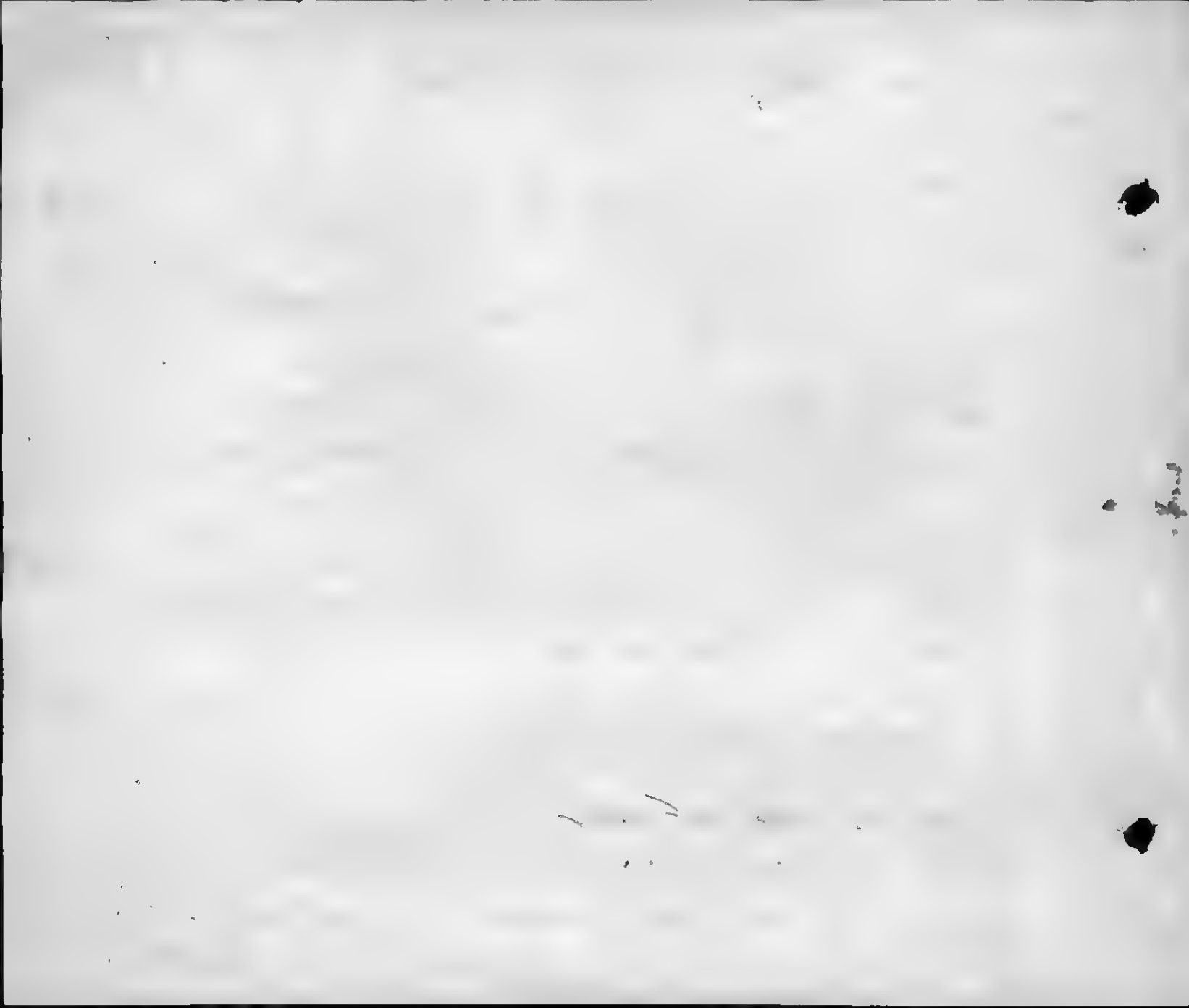
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13489

13510 Items 8, 9 Film 6253 12-21-59 et

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethlehem Steel Dispensary</u>				d. STREET ADDRESS <u>2500 Yorkway</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES RICHARD STEALEY, Sr</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>1903</u> <u>Sept. 9, 1905</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>56</u> Days <u>34</u>	IF UNDER 24 HRS. Hours <u>56</u> Min. <u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Stealey</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>235-12-2267</u>		17. INFORMANT <u>Mrs. Anna Stealey 2500 Yorkway</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Russell S. Fisher</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <u>12/7/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or country) _____ (State) _____ <u>Colgate, Md.</u>	
23. FUNERAL DIRECTOR <u>Ulrich Funeral Home Dundalk, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Crother S. Kinn</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

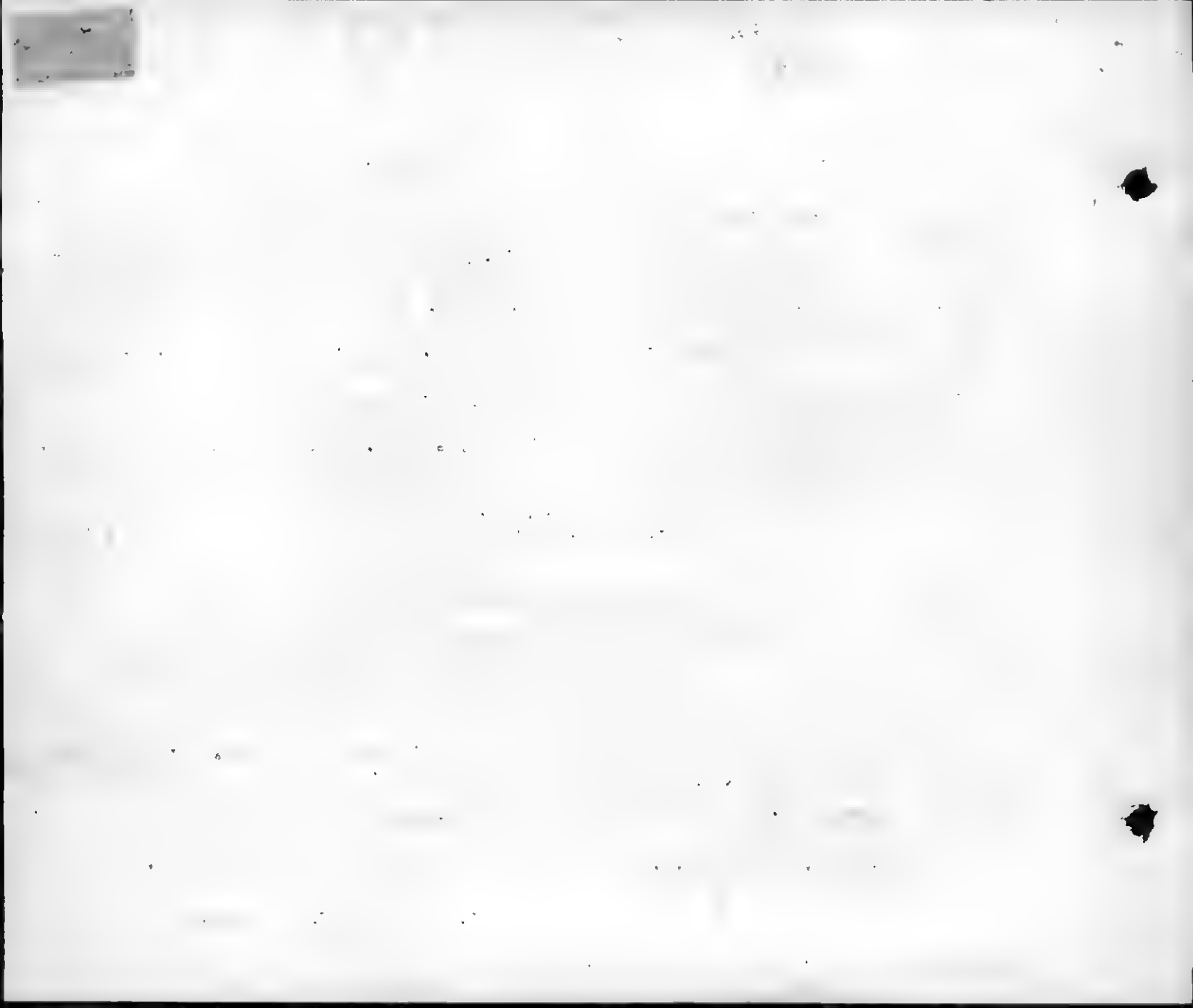
Reg. Dist. No.

13490

13511

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>55 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>k1 2905 Oakley Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>R</u> Last <u>STEINER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 30, 1932</u>
9. AGE (In years last birthday) <u>27 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.A</u>	
13. FATHER'S NAME <u>Louis Steiner</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Block</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>215-28-3671</u>	
INFORMANT <u>Clin. Rec. Vet. Adm. Hosp. Balto Md Ft Howard Div.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO <u>POST OPERATIVE SUB TOTAL COLECTOMY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ULCERATIVE COLITIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>7 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 14, 1959</u> to <u>December 29, 1959</u> and that the deceased was <u>alive on</u> <u>November 18, 1959</u> and that death occurred at <u>9:20 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>12/29/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. POWDER, M.D.</u>		<u>VAH BALTO MD FT HOWARD DIVISION</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Entaw Place Balto. Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

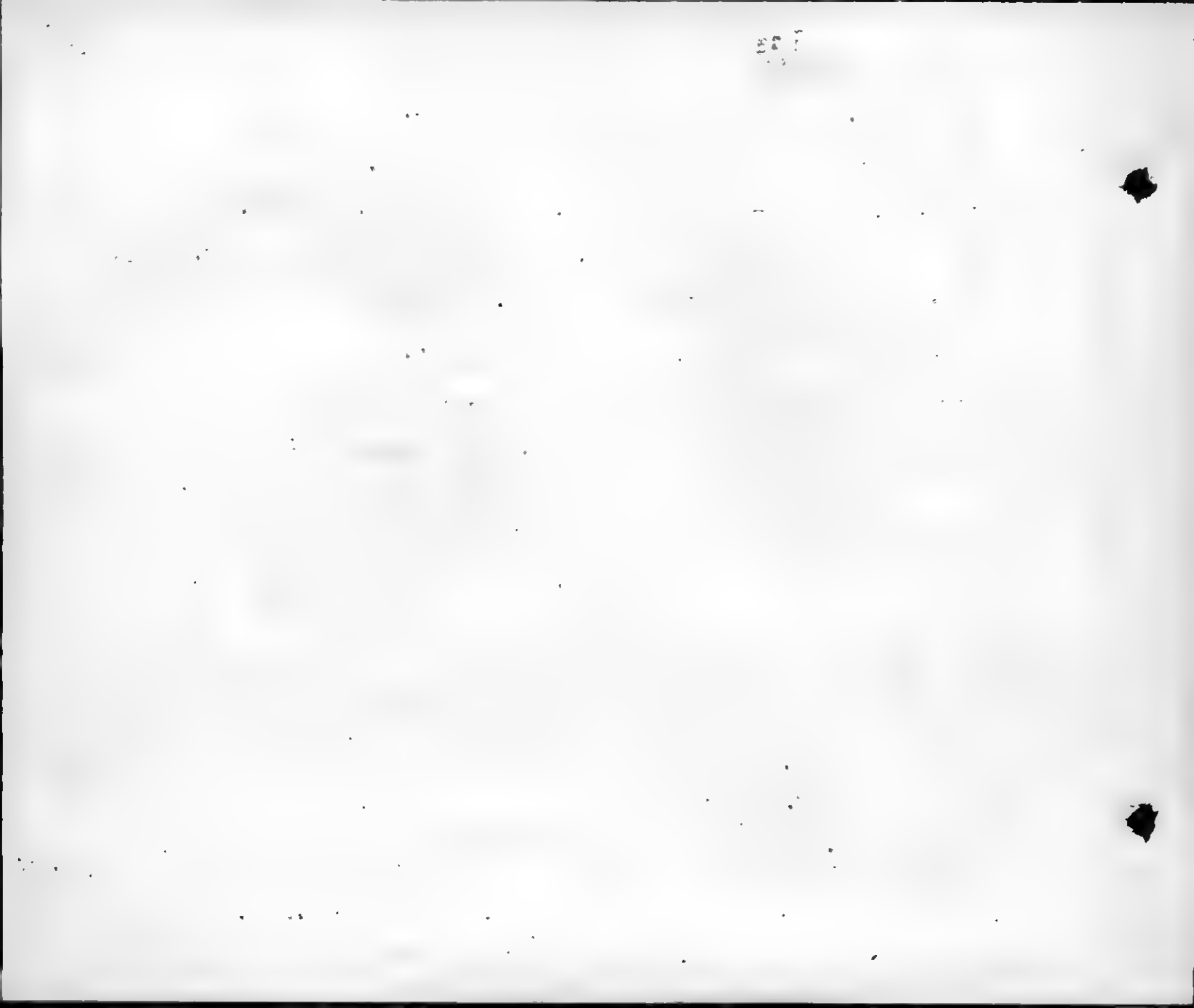
13491

13512

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home-98 Smithwood Ave.				d. STREET ADDRESS 1411 S. Carey St.			
3. NAME OF DECEASED (Type or print) First DAISY Middle M. Last STEWART				4. DATE OF DEATH Month Dec. Day 5, Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1879	
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Burgess			
14. MOTHER'S MAIDEN NAME Agnes				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT Mrs. Dollie Tracey - 402 Lee Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accidents DUE TO Multiple Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. Congrene lower extremities DUE TO Blood PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blood				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19 59 to 12/5/59 , that I last saw the deceased alive on 12/5/59 , and that death occurred at 11:15 P.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 12/7/59			
ACTUAL SIGNATURE W. E. McGroth M.D.				PHYSICIAN'S NAME (Type) W. E. McGroth			
22a. BURIAL, CREMATORY, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jim J. Pickens				24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneave	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13492

13513

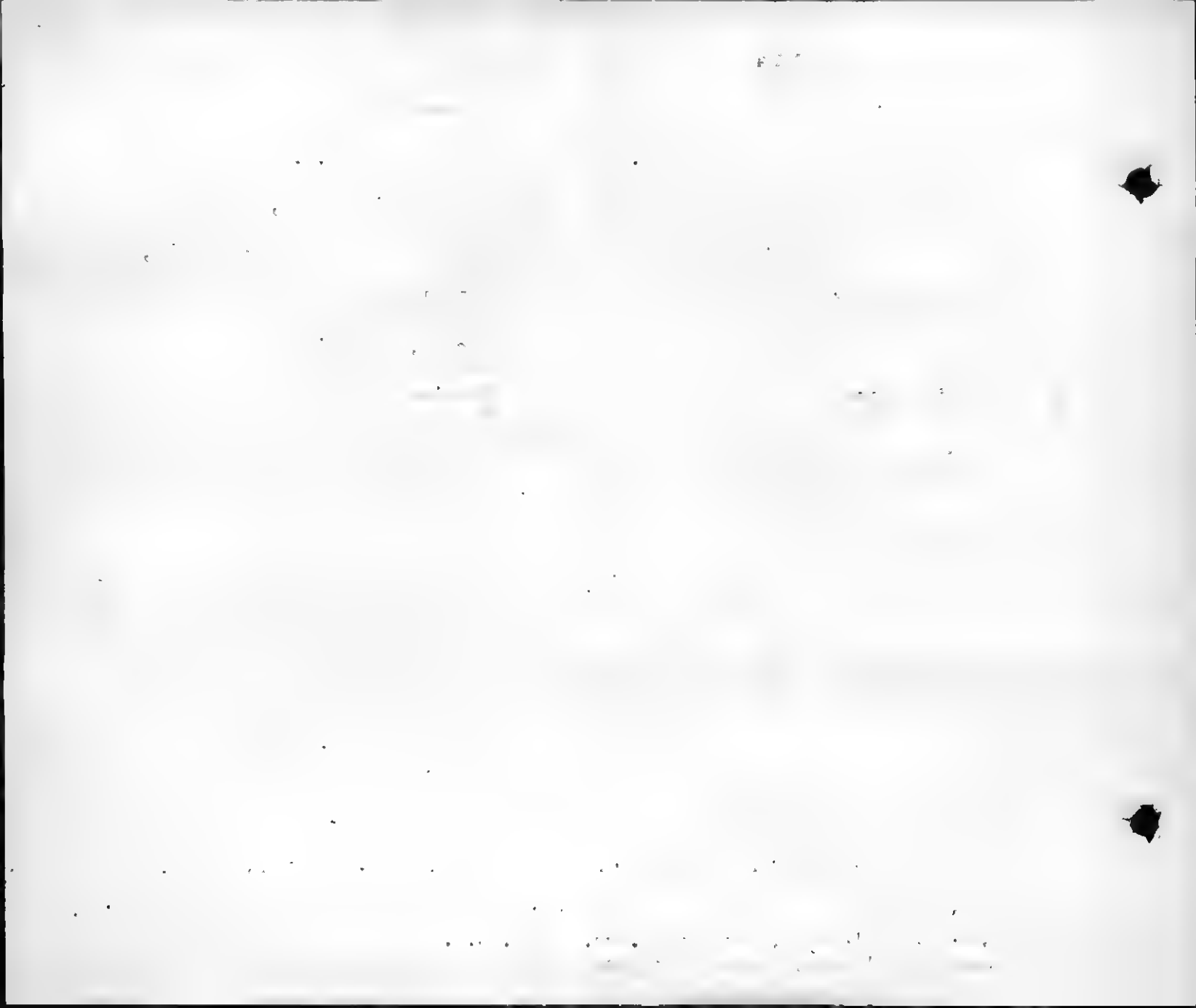
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Washington b. COUNTY DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 3 mon. 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Aged Home		e. STREET ADDRESS 2205 California Avenue, NW	
3. NAME OF DECEASED (Type or print) First FRANCES Middle K Last STILLWELL		4. DATE OF DEATH Month December Day 14 , Year 1959	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1878
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rollin Keys		14. MOTHER'S MAIDEN NAME Katherine Keys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO years (c) Generalized arteriosclerosis DUE TO years		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 59 , to present , 19 59 , that I lost saw the deceased alive on Sept 12 , 19 59 , and that death occurred at 12:55AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest C Brown Jr		ADDRESS (Street, city or town, state) DATE SIGNED Balt-2 Md 12-14-59	
PHYSICIAN'S NAME (Type) Ernest C. Brown, Jr.		1101 N. Calvert St., Baltimore 2, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Removal/Burial		22b. DATE THEREOF 12-16-59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, 1756 Penna. Ave., Wash. D.C. John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE DEC 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1 X

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



13514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>724 Washington Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>Stotelmyer</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/53</u>
9. AGE (In years last birthday) <u>6</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lewis Victor Stotelmyer</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Wharton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u> </u>		INFORMANT <u>Rosewood Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Microcephaly with broncho-</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pneumonia and otitis med.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>3:16a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave Baltimore 14, Md</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		DATE SIGNED <u>12/22/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>1715 Hoffman Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13516

CERTIFICATE OF DEATH

13494

Reg. Dist. No.

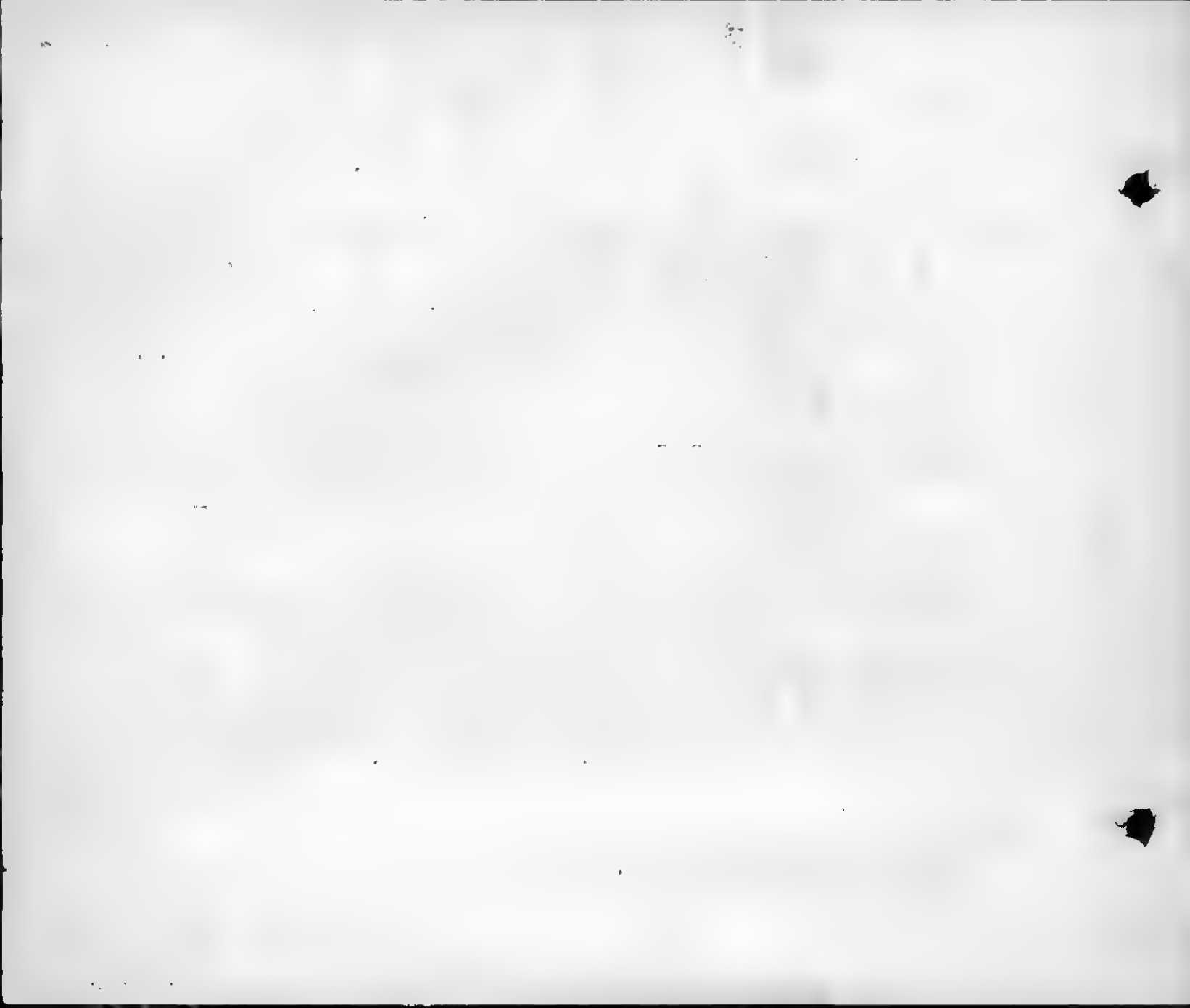
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9 years		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 26 Midship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Strapple				4. DATE OF DEATH Month Day Year Dec. 26 19 59			
5. SEX Male		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED		8. DATE OF BIRTH March 13, 1911	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Anthony Strapple				14. MOTHER'S MAIDEN NAME ANNA Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 192-01-8688		17. INFORMANT Address Spring Grove State Hospital's Records			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 7 + 5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 24 , 19 59 to Dec. 26 , 19 59 , that I last saw the deceased alive on Dec. 26 , 19 59 , and that death occurred at 8:10a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Spring Grove State Hospital 12-28-59			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/60		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Somerset Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Kelpha Funeral Home Windsor, Pa.				24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

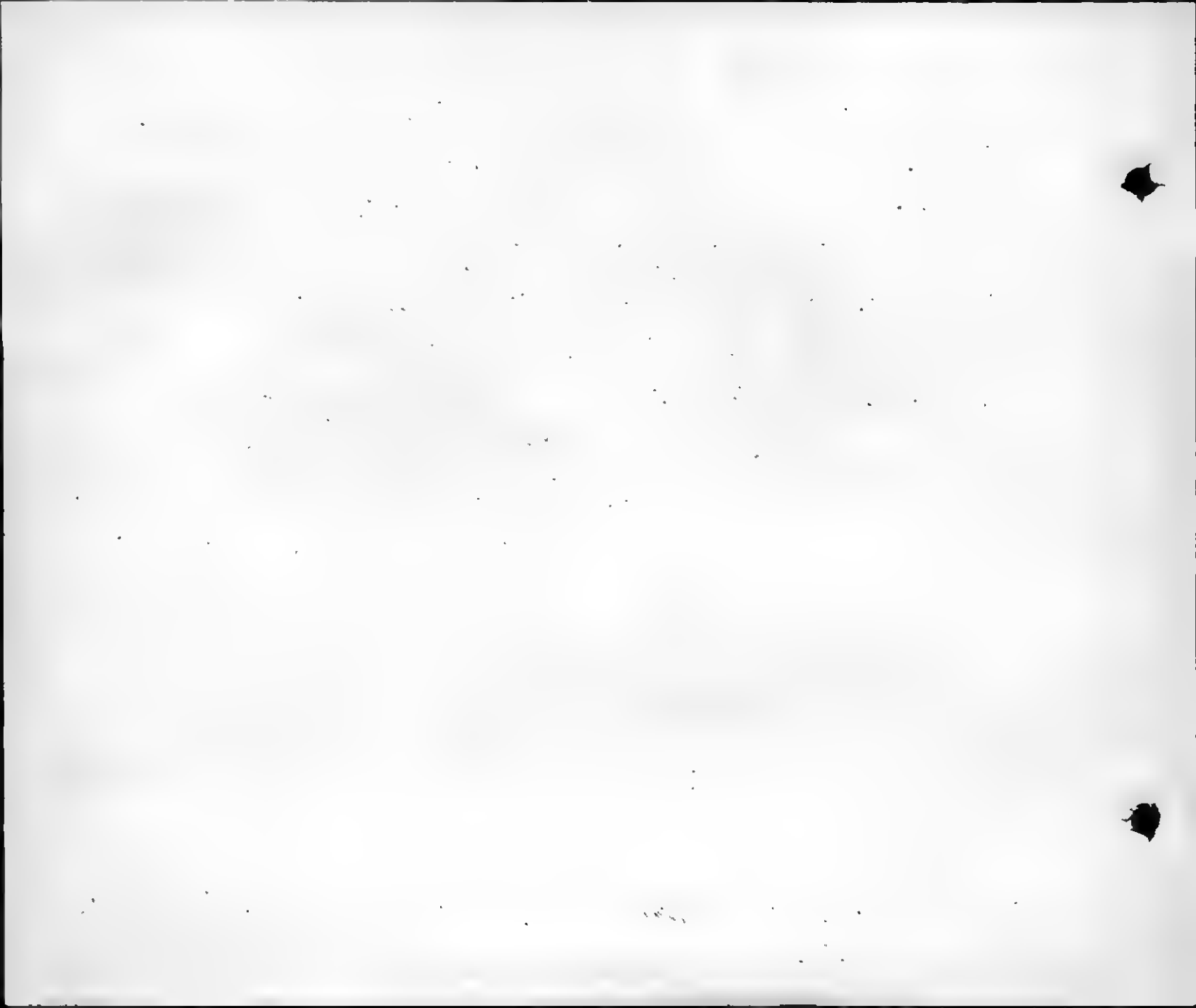
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13516
CERTIFICATE OF DEATH

Reg. Dist. No.

13495

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN 1b <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Caton Ridge Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harry C. Stults</i>		4. DATE OF DEATH <i>Dec. 21 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/26/66</i>
9. AGE (In years last birthday) <i>93</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumbing Self Emp.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. A. Stults</i>		14. MOTHER'S MAIDEN NAME <i>Anna Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Madeline Castle</i>	
17. INFORMANT Address <i>Madeline Castle</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Age</i> DUE TO <i>Coronary Arteriosclerosis</i> (b) <i>Unknown</i> (c) <i>Age</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>Dec 21</i> , 19 <i>59</i> ; that I last saw the deceased alive on <i>Dec 21</i> , 19 <i>59</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Cliff Ratliff Jr.</i>		DATE SIGNED <i>12/23/59</i>	
PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF JR.</i>		<i>Balto. Co. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/24/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Staten Reformed Ch.</i>		22d. LOCATION (City, town or county) (State) <i>Middleton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Ratliff + don 28</i>		24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



FOR STATE HEALTH DEPT.

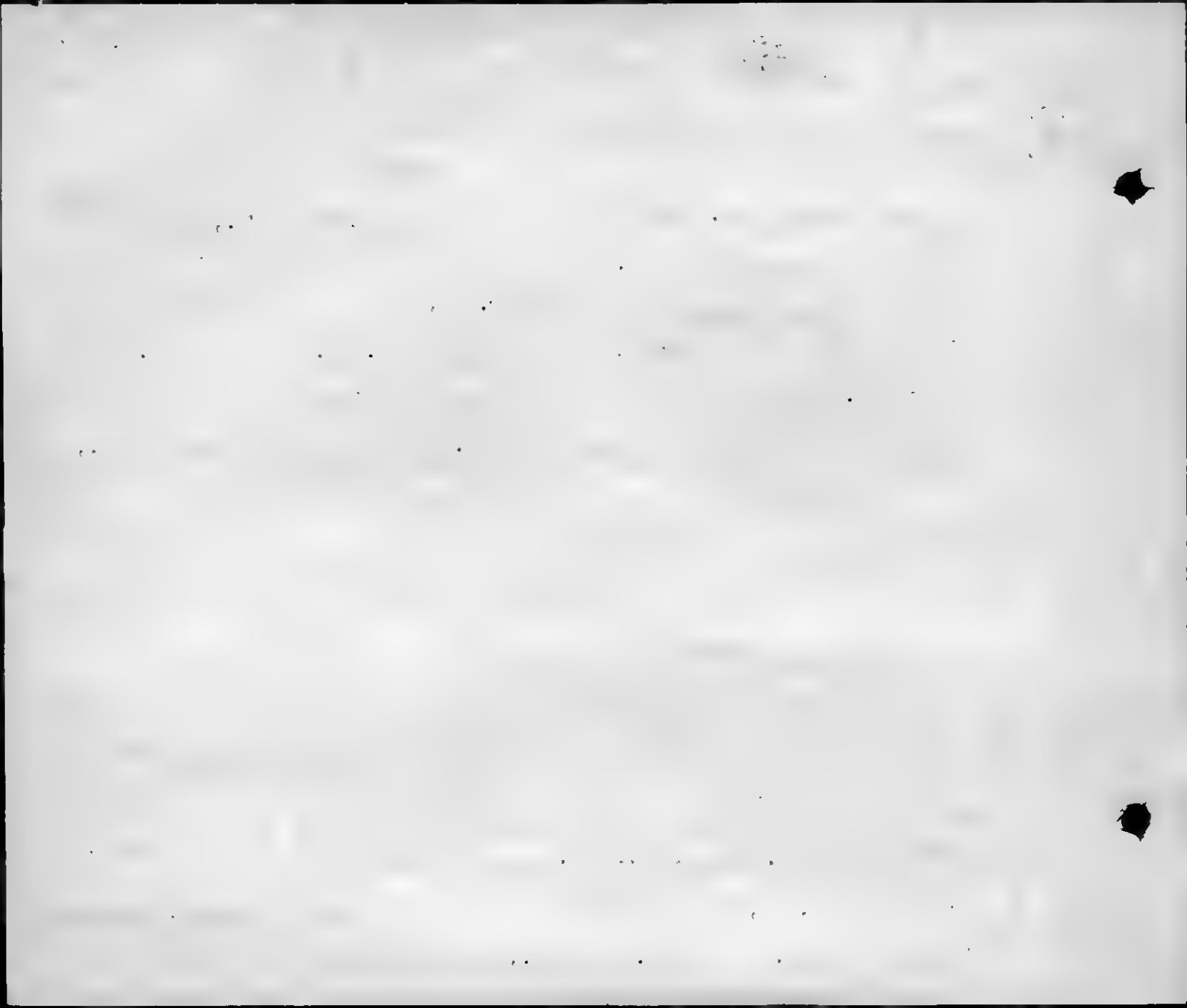
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

20-21 Film 254
1-8-60
MAY 1961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
HOSPITAL EXAMINER'S CERTIFICATE OF DEATH 13496

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2411 Rockwell Ave. (garage)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 2411 Rockwell Ave.,	
3. NAME OF DECEASED (Type or print) GEORGE S. SULLIVAN		4. DATE OF DEATH December 10, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 10	IF UNDER 24 HRS. Hours 10 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S?A		13. FATHER'S NAME Frank B. Sullivan	
14. MOTHER'S MAIDEN NAME Carrie Blizzard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-05-9357		17. INFORMANT Hazel M. Sullivan Address 2411 Rockwell Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Inhaled carbon monoxide while sitting in an automobile	
20c. TIME OF INJURY Month, Day, Year Undetermined 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) garage	20f. City or town (County) (State) Catonsville Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. William V. Lovitt, Jr., M.D.	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 12/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
22d. LOCATION (City, town, or country) (State) Baltimore County, Maryland		23. FUNERAL DIRECTOR ADDRESS William Cook Inc. 1217 St. Paul St.,	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	



13518

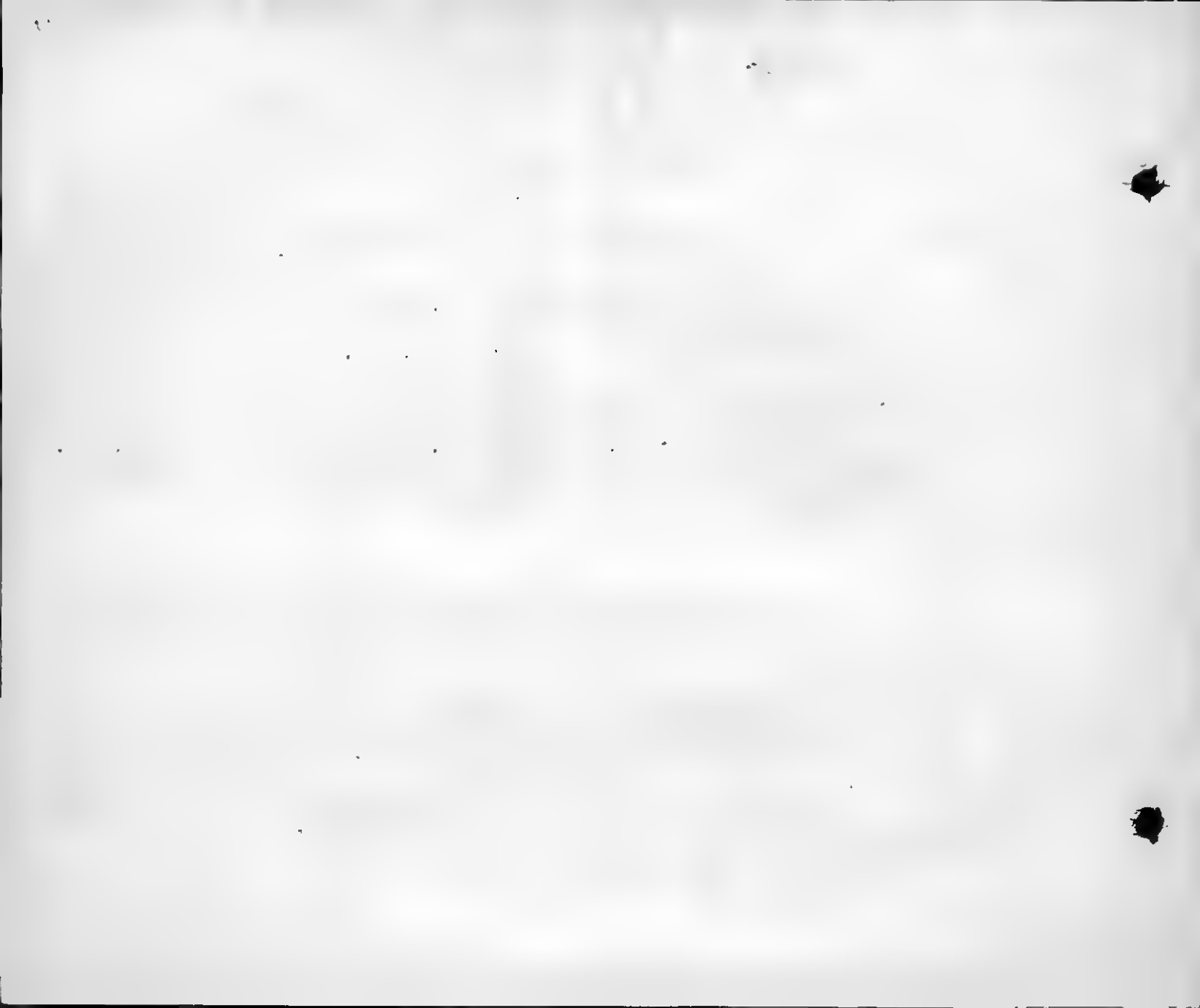
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 		d. STREET ADDRESS <u>Troyer Road</u>	
3. NAME OF DECEASED (Type or print) <u>Ada Frances</u> <u>Swift</u>		4. DATE OF DEATH <u>Dec. 9</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1985</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Monkton, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lewis M. Troyer</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza Jane Melvin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-36-2685 D</u>		17. INFORMANT <u>Miss. Jane Swift</u> <u>Monkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio vascular disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 3</u> 19 <u>59</u> , to <u>Dec. 7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 9</u> 19 <u>59</u> , and that death occurred at <u>8</u> PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Monkton, Md.</u> DATE SIGNED <u>12/10/59</u> ACTUAL SIGNATURE <u>A. M. France</u> M.D. PHYSICIAN'S NAME (Type) <u>A. M. France</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Monkton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Adrian S. Hunt</u>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 10/57



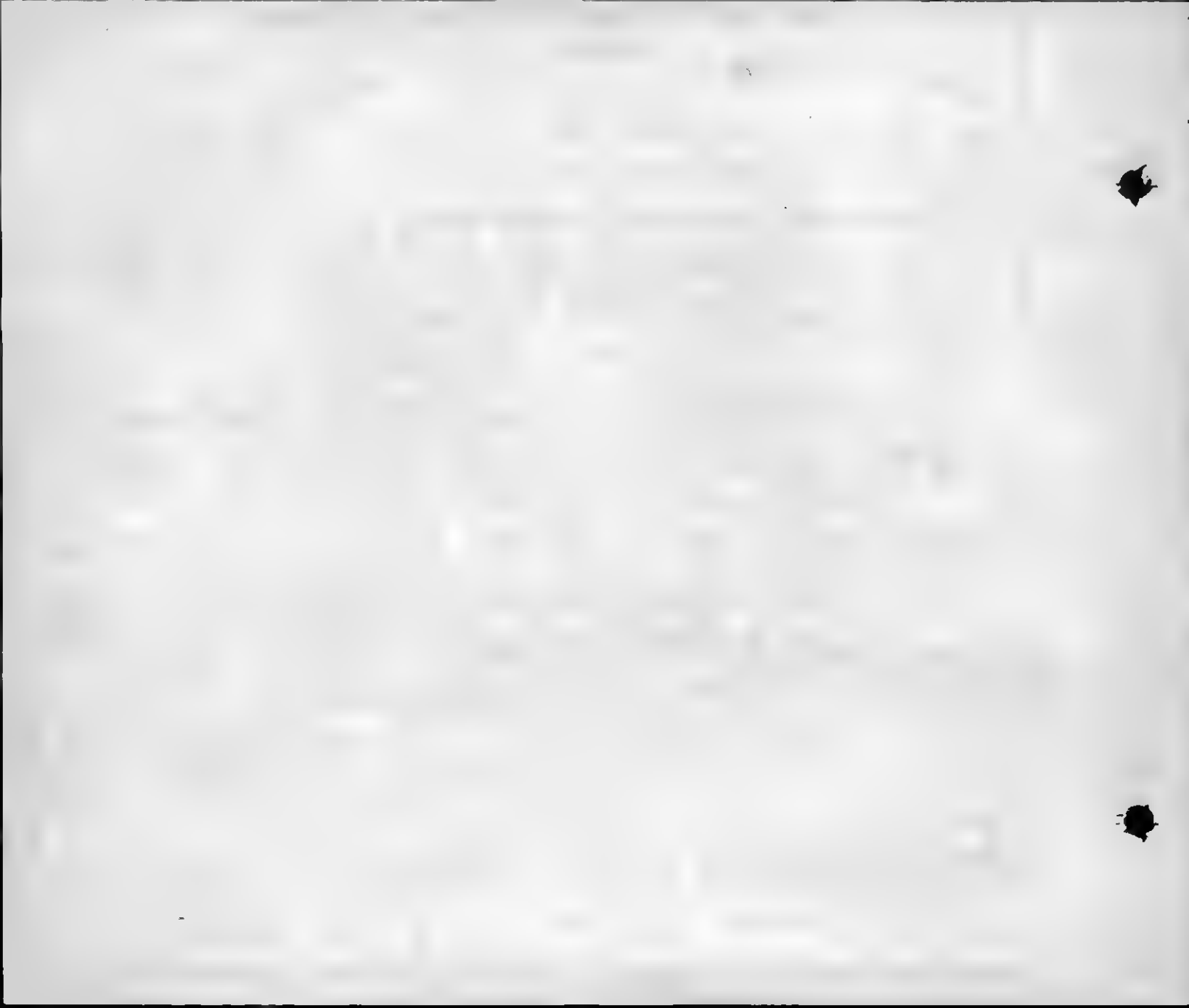
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 YRS CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES</u>		e. STREET ADDRESS <u>2122 ALVIN AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD THOMPSON</u>		4. DATE OF DEATH Month Day Year <u>DEC. 9, 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METER READER & REPAIRS GAS & ELECT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>OLIVER THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HAMILTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-264959</u>	
17. INFORMANT <u>MRS. VICTOR BUETE FISC</u>		Address <u>2217 PLEASANT DR. CATONSVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coxsack Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcohol poisoning</u> DUE TO (c) <u>Asphyxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u> <u>Bleeding</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1958</u> , to <u>Dec 8, 1959</u> , that I last saw the deceased alive on <u>Dec 8, 1959</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 EDMONDSON</u> DATE SIGNED <u>12/14/59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>		<u>BALTO 29, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u> ADDRESS <u>CATONSVILLE, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

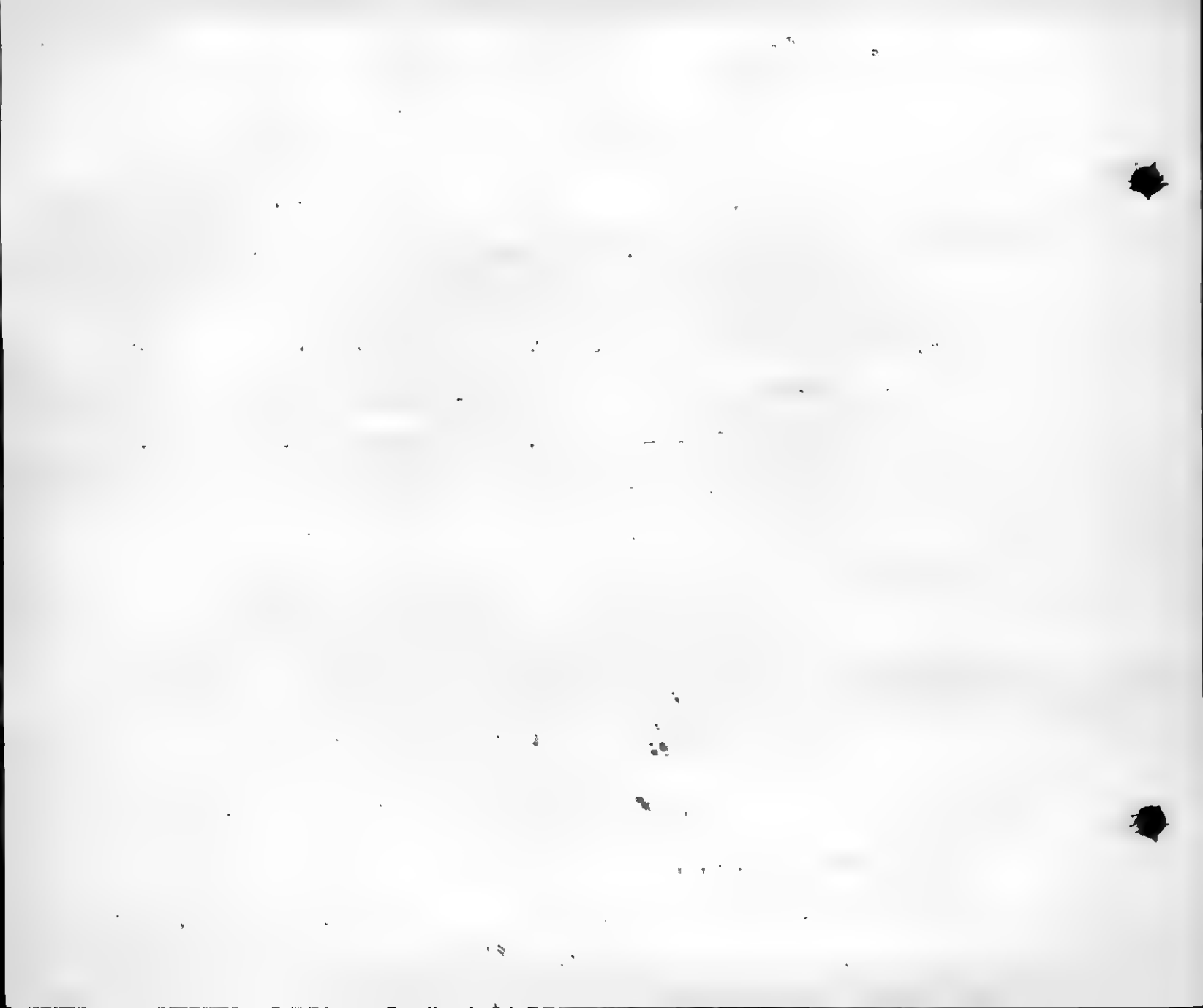
Reg. Dist. No. 13499

13520

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1732 Amuskai Rd.		d. STREET ADDRESS 1732 Amuskai Rd.	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Traband		4. DATE OF DEATH Month December Day 12 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1899
9. AGE (In years last birthday) yrs 60		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & seal	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Traband		14. MOTHER'S MAIDEN NAME Clara Enge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-3484	
INFORMANT Address Mrs. Nellie Traband 1732 Amuskai Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's disease 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO (c) 5yr			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 , 19 48 , to 12/12 , 19 59 , that I last saw the deceased alive on 12/12 , 19 59 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon Grau		ADDRESS (Street, city or town, state) 8513 Loch Raven Bldg DATE SIGNED 12/14/59	
PHYSICIAN'S NAME (Type) Gordon Grau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-1959	
22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE DEC 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13521

CERTIFICATE OF DEATH

13500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 10706 Reisterstown Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Turnbaugh		4. DATE OF DEATH Month December Day 12 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1888
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handy man		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Turnbaugh		14. MOTHER'S MAIDEN NAME Martha	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216-14-4815	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Occlusion (c) Generalized arteriosclerosis (cardiovascular & aortic) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 29, 1959 to Dec. 12, 1959 , that I last saw the deceased alive on Dec. 11, 1959 , and that death occurred at 1:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edward T. Schaefer M.D. SPRING GROVE STATE HOSPITAL PHYSICIAN'S NAME (Type) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 15-1959	
22c. NAME OF CEMETERY OR CREMATORY Reisterstown Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Berryman		ADDRESS Reisterstown, Md.	
24a. RECEIVED BY REGISTRAR DATE DEC 15 59		24b. REGISTRAR'S SIGNATURE Charles L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13337

CERTIFICATE OF DEATH

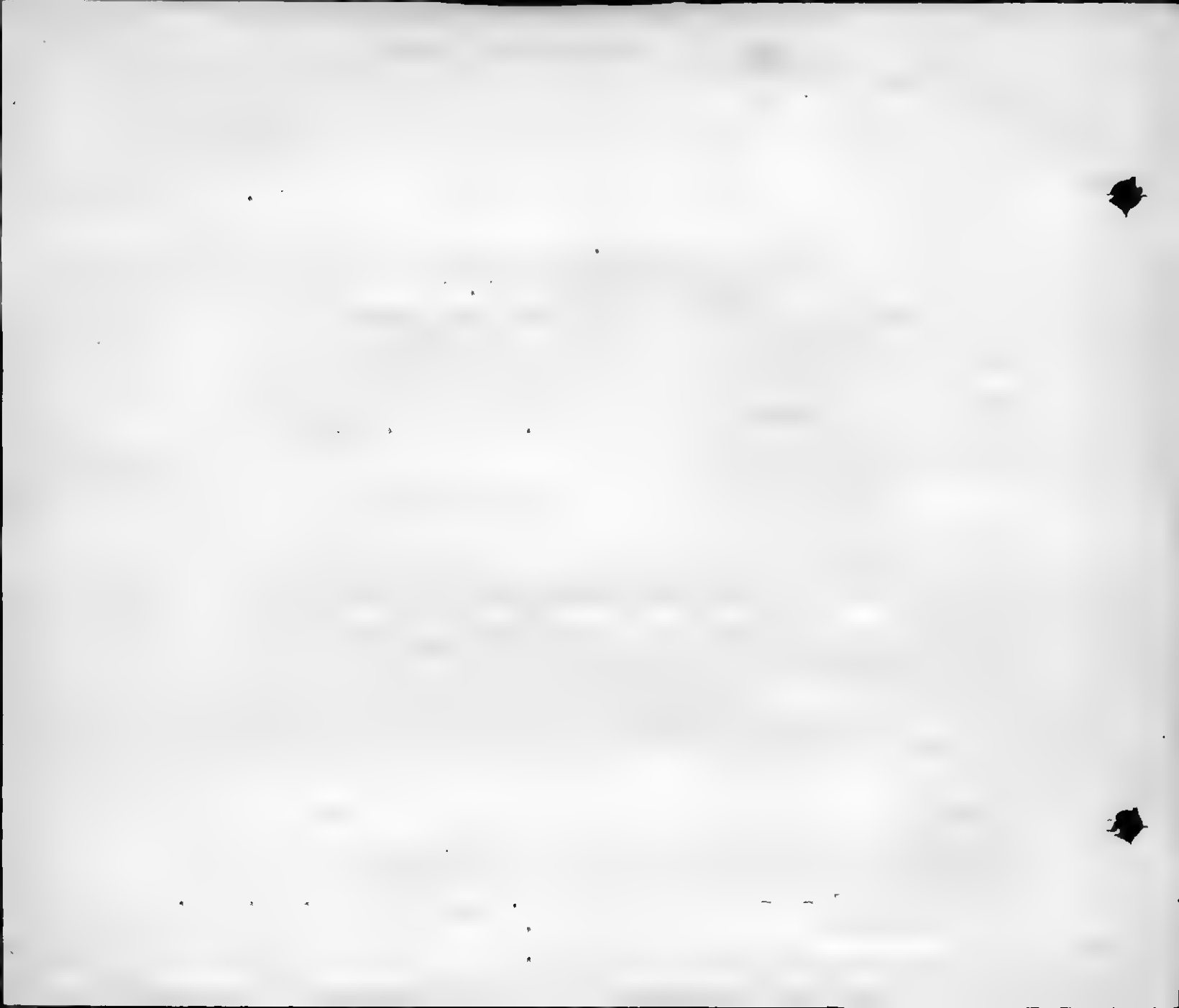
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland	b. COUNTY	Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Halethorpe	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2034 Northeast Ave		d. STREET ADDRESS		2034 Northeast Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Walter	Middle T.	Last Turner	4. DATE OF DEATH		Month December	Day 18,	Year 19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.	
Male	Colored		Jul. 1, 1891						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Teacher				Maryland		U. S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
Unknown			Sidney ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address		Mrs. Gladys C. Turner 2034 Northe ast Av			
(Yes, no, or unknown)		(If yes, give war or dates of service)							
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 5 yrs approx	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-26-1958, to 11-26-1959, that I last saw the deceased alive on 11-26-1959, and that death occurred at 3 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE H Wasserman		M.D. 1501 Eutaw Place							
PHYSICIAN'S NAME (Type) Dr. Harry Wasserman		Baltimore 17 MD							
22a. BURIAL, CREMATION, RE interment (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		12-22-59		Arbutus Mem. Park		Balto. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
H. Wasserman		578 W. Biddle St.		DATE DEC 28 '59		Arthur L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13502

Reg. Dist. No.

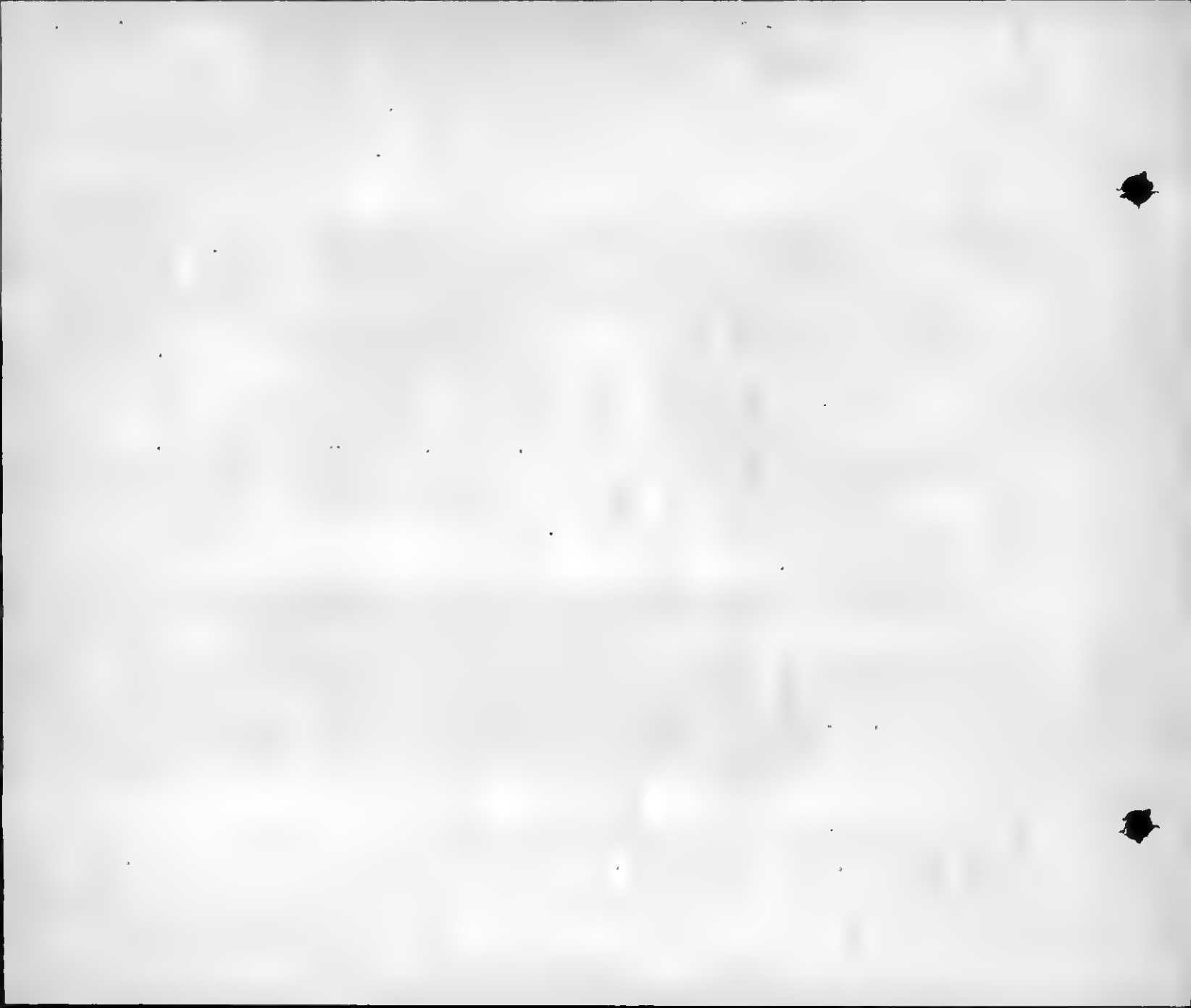
13522

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1024 Crosby Rd.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 1024 Crosby Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle Peirce Last Tyler		4. DATE OF DEATH Month Dec. Day 18, Year 19 59	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1927
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Peirce		14. MOTHER'S MAIDEN NAME Stelle Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Address Mr. John W. Tyler - 1024 Crosby Rd. Catonsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gas poisoning from automobile DUE TO Carbon monoxide. Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Suicide DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rubber tube attached to exhaust of auto, into car, causing death by Carbon Monoxide	
20c. TIME OF INJURY Month, Day, Year How 20 A. 12-18-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Car at home	20f. (City or town) Catonsville (County) also, Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		DATE SIGNED Dec. 18, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/21/59	22c. NAME OF CEMETERY OR CREMATORY Warsaw Cemetery	22d. LOCATION (City, town, or county) (State) Warsaw, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - 1770 - 17, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kneale

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



917
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13523 CERTIFICATE OF DEATH

13508

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

CHARLES H. VINSON

2. DATE OF DEATH

Dec. 29, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Armacost Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE
Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1423 Kingsway Rd.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Dec. 18, 1872

9. AGE (In years last birthday)

87

If Under 1 Year

Months Days Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Light House

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Vinson

14. MOTHER'S MAIDEN NAME

Elizabeth Zeis

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Miss Anna V. Vinson - 1423 Kingsway Rd.

ADDRESS

18. I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Gall Bladder

6 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

Dec 29

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

WORK ☐ AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from December 12, 1959 to December 29, 1959, that (I) (no) last saw the deceased alive on December 26, 1959, and that in (my) (our) opinion death occurred at 4:52 a.m., from the causes and on the date stated above.

23A. SIGNATURE

A. Allan Smith

23B. ADDRESS

M.D.

4408 Loch Raven Blvd

23C. DATE SIGNED

12/29/59

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/31/59

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY REGISTRAR

DEC 30 1959

REGISTRAR'S SIGNATURE

Arthur S. Thomas

25. FUNERAL DIRECTOR

Wm. L. Lockman & Sons

ADDRESS

THIS IS A PERMANENT RECORD
PLEASE TYPE, OR IN PERMANENT BLACK OR BLUE-BLACK INK--DO NOT USE A BALL POINT PEN

Every item of information carefully supplied. Physicians: please write the causes of death clearly and legibly.
THIS CERTIFICATE MUST BE THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER D



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 143. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&20 Film 254

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13504

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex
c. LENGTH OF STAY IN IL Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Middle River Rd. and Martin Blvd.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 407 A Ballard Street

3. NAME OF DECEASED (Type or print)
First Middle Last
GEORGE DAVID VOLZ

4. DATE OF DEATH
Month Day Year
December 14 19 59

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH
October 7, 1897 9. AGE (In years last birthday) 62 yrs. 10. MONTHS 14 11. DAYS 19 12. HOURS 59 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Volz 14. MOTHER'S MAIDEN NAME Lena Richert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. Henry Volz 17. INFORMANT 7 Volz Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive third degree burns and carbon monoxide poisoning complicating massive fresh intracerebral hemorrhage in white matter of left lower parietal lobe.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hypertensive arteriosclerotic heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

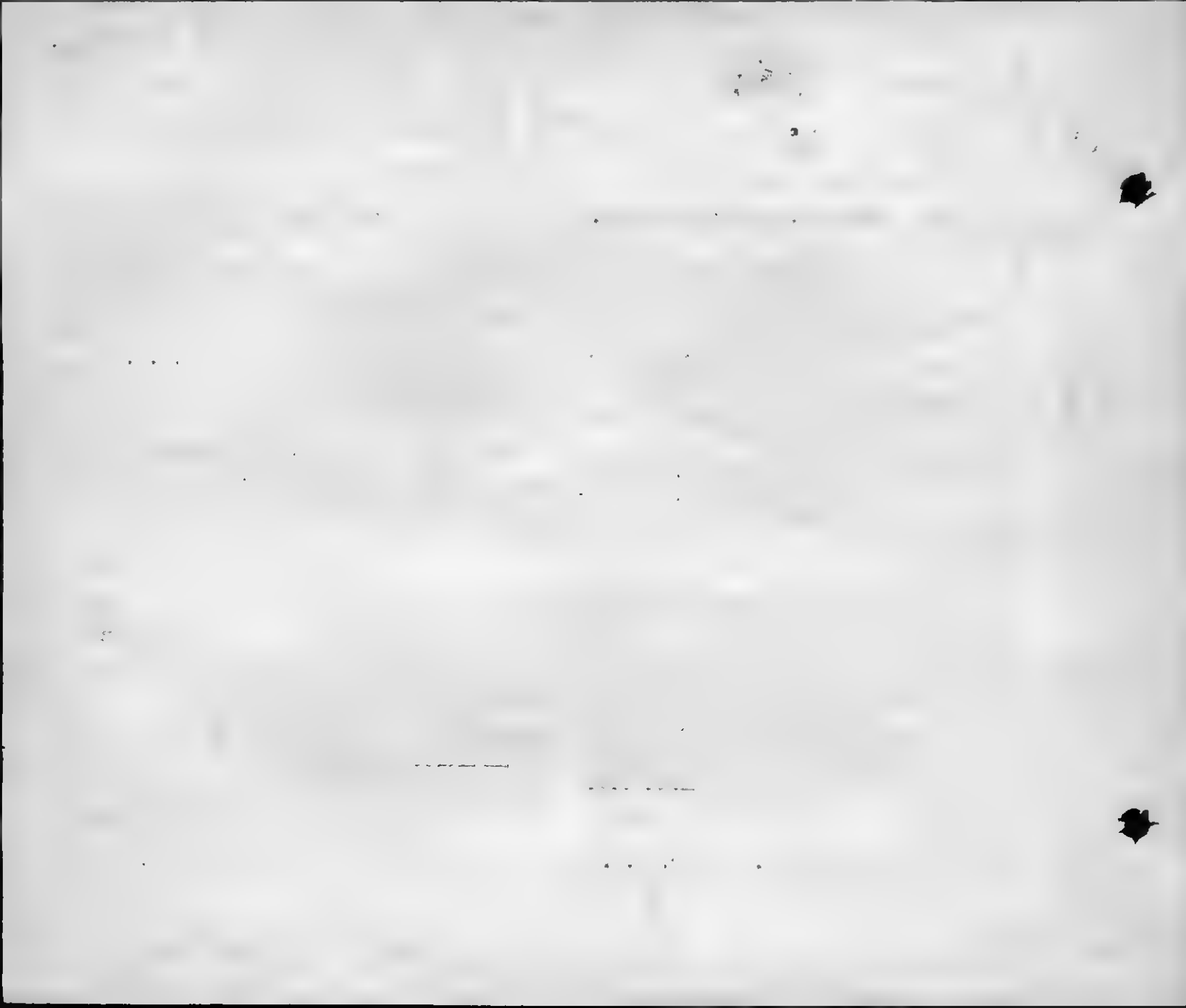
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH. Deceased was found in burning shack containing xmas trees. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 12 14 59 20d. INJURY OCCURRED While ☒ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking lot 20f. (City or town) Essex (County) Baltimore (State) Maryland

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
NAME (Type) Russell S. Fisher, M.D. Address (Street, city, town, or county) 12/14/59

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF DEC 16, 1959 22c. NAME OF CEMETERY OR CREMATORY ZION LUTHERN CEM. 22d. LOCATION (City, town, or country) (State) STEMMERS RUN MARYLAND

23. FUNERAL DIRECTOR Jassahn Funeral Home 7401 Belair Road #6 ADDRESS DATE DEC 17 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Huns



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13505

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 1/2 hr.</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale Balti 7.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randallstown 2nd St</u>				d. STREET ADDRESS <u>3823 Washington Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>CLIFTON</u> Last <u>WAGNER</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Insurance Agent. Life Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>W.S.G.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>W.S.G.</u>							
13. FATHER'S NAME <u>Eustace Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Myrtle E. Wagner</u> Address <u>3823 Washington Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angina Pectoris</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Dec 21 '59</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL (CREMATION REMOVAL) (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Road, Randallstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the State, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



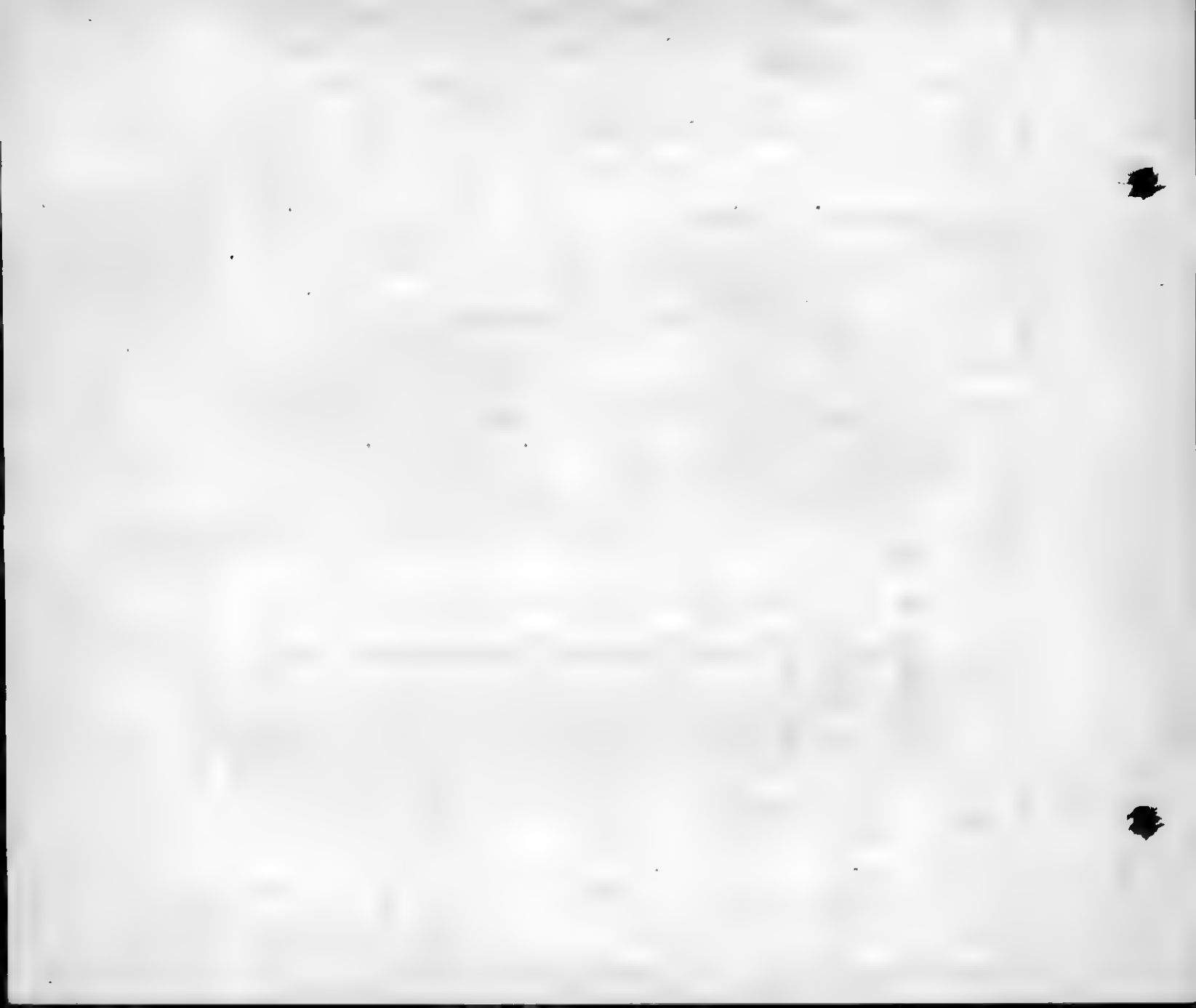
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13506

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>717 Sutter Ave. Apt B.</u>		d. STREET ADDRESS <u>717 Sutter Ave. Apt. B</u>	
3. NAME OF DECEASED (Type or print) <u>Abraham Walters</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 10 3144</u>	
17. INFORMANT <u>Mrs. Lila Walters</u>		Address <u>717 Sutter Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. J. M. Kieller</u>		DATE SIGNED <u>Dec. 20, 1959</u>	
EXAMINER'S NAME (Type) <u>Geo. J. M. Kieller M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cem. Balto.</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Williams</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 '59</u>	
ADDRESS <u>322 W. Woodward</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 7 111.3.24 1-4-60 et

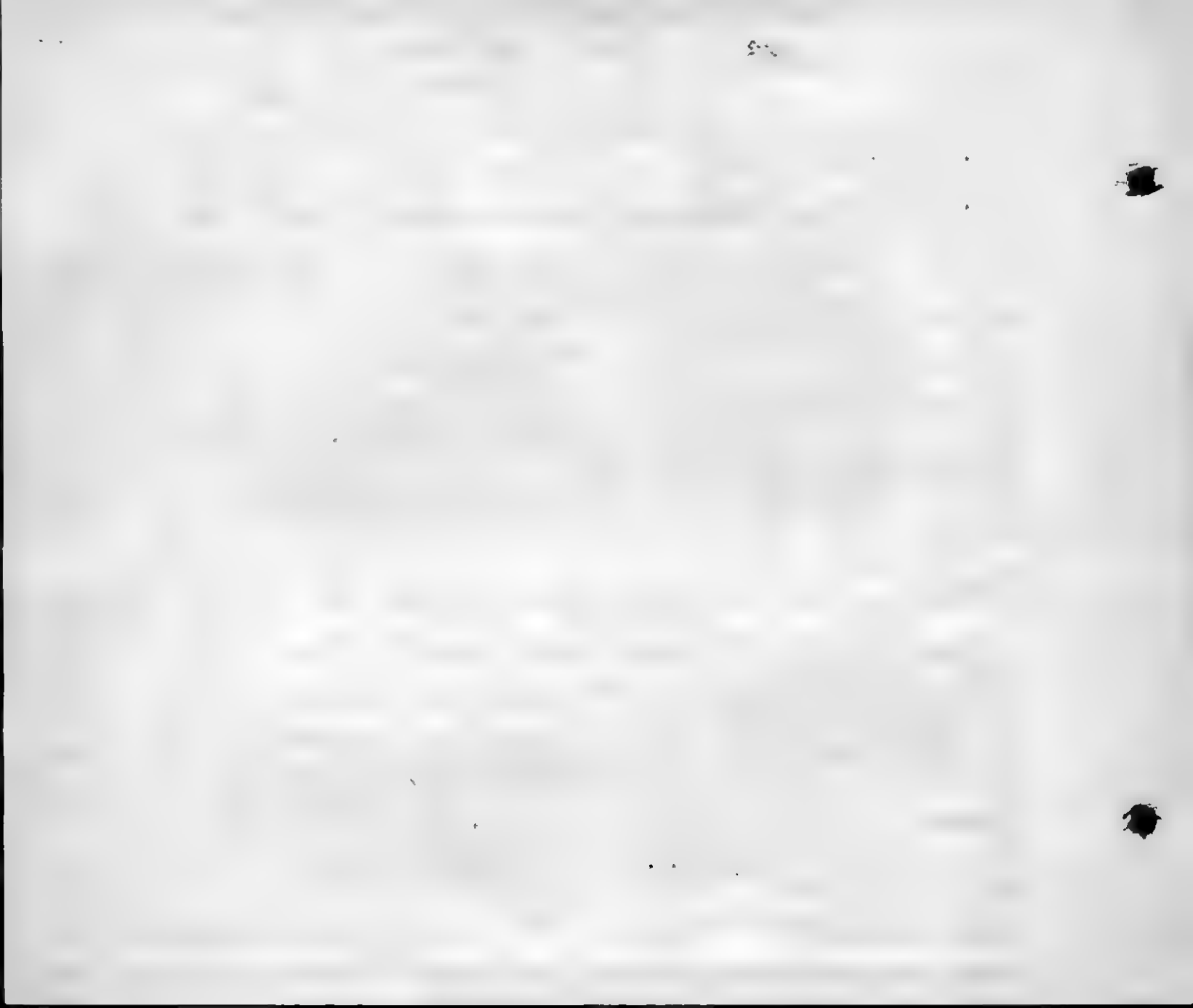
13527

CERTIFICATE OF DEATH

Reg. Dist. No. 32

13507

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md.		b. COUNTY Hartford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 6 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 317A R.D.#2, Loppa, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emanuel Chester Waters		First Middle Last		4. DATE OF DEATH 12 31 1959		Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1882		9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Waters				14. MOTHER'S MAIDEN NAME Viola May Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 62 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3 1954 to 12/31 1959, that I last saw the deceased alive on 12/31 1954, and that death occurred at 6:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Mt. Wilson, Maryland							
ACTUAL SIGNATURE M.D.							
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Bailey		ADDRESS Hartington		24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

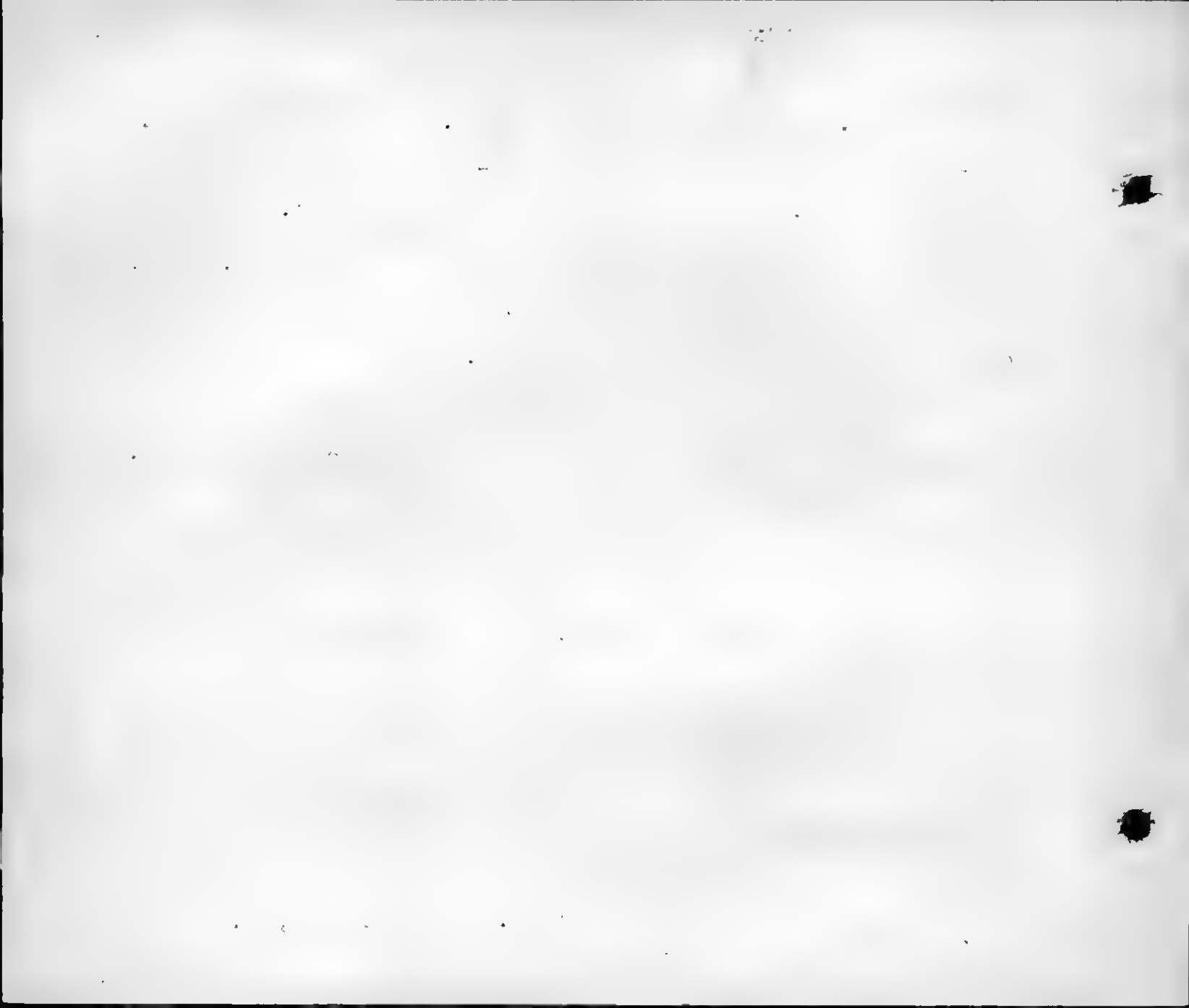
13528

CERTIFICATE OF DEATH

Reg. Dist. No.

13508

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>402 Regester Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIA EMMA WELCH</u>		4. DATE OF DEATH Month Day Year <u>Dec. 26, 1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Teacher</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
13. BIRTHPLACE (State or foreign country) <u>Md.</u>		14. CITIZEN OF WHAT COUNTRY?	
15. FATHER'S NAME <u>Mordecai Welch</u>		16. MOTHER'S MAIDEN NAME <u>Rhoda Armiger</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		18. SOCIAL SECURITY NO. <u>none</u>	
19. INFORMANT <u>Miss Rhoda Hamilton</u>		Address <u>402 Regester Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Left Kidney</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hiatus Hernia Dextrocardia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 23</u> , 19 <u>59</u> , to <u>Dec 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>59</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Peare</u> M.D.		ADDRESS (Street, city or town, state) <u>2105 N. Charles St. Baltimore 18 Md.</u>	
PHYSICIAN'S NAME (Type) <u>William F. Peare</u>		DATE SIGNED <u>12/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey L. Lerner</u>		ADDRESS <u>1717</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

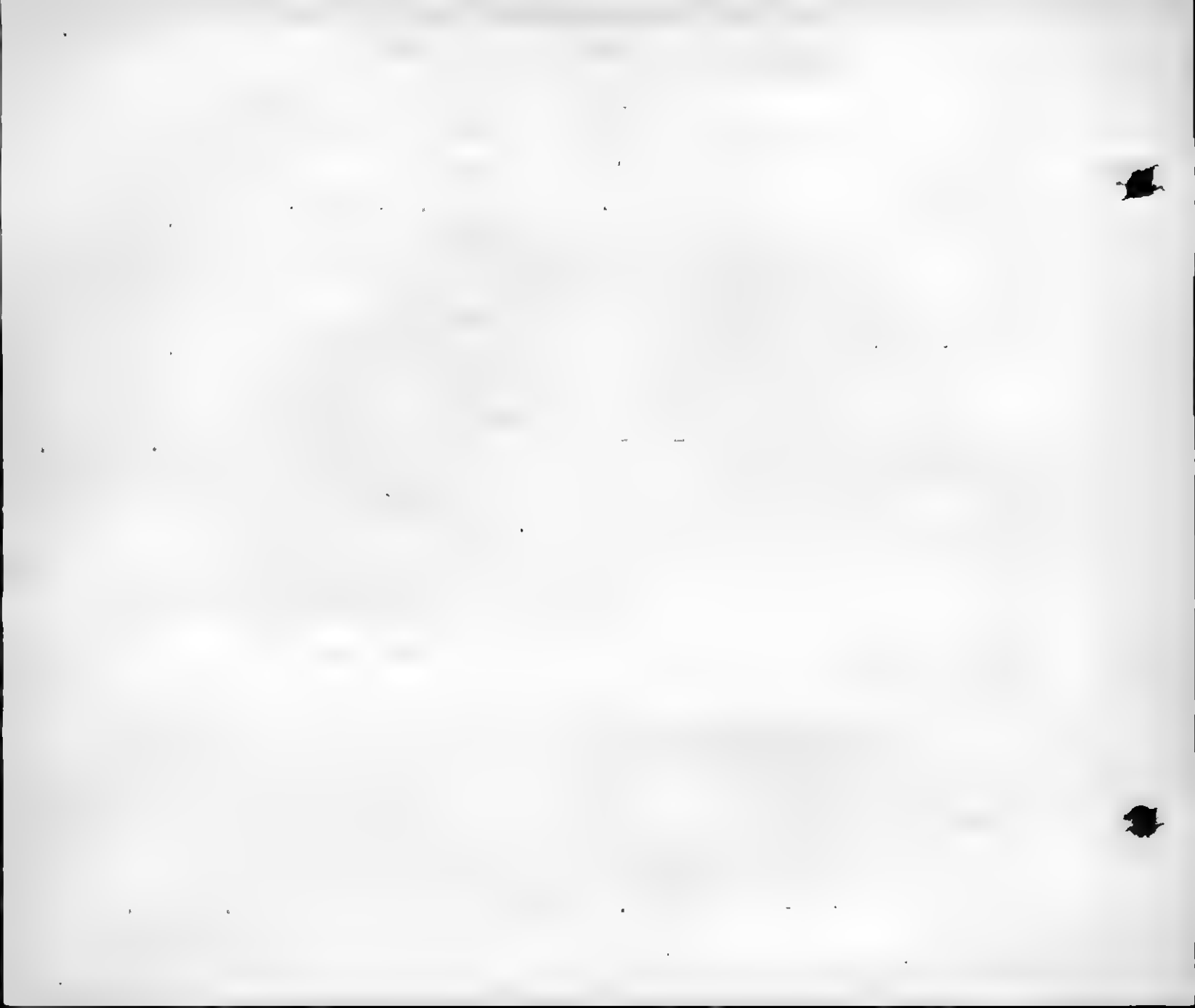
13335

CERTIFICATE OF DEATH

Reg. Dist. No.

13509

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 3 Mo.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore d. STREET ADDRESS Box 25, N. Point & Millers Island Rd.	
3. NAME OF DECEASED (Type or print) First Annes Middle Katherine Last West		4. DATE OF DEATH Month December Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Lawrence Drozdowski		14. MOTHER'S MAIDEN NAME Katherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 212-129-977	
17. INFORMANT Address Dr. Charles West 114 Wise Ave. 22, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 10 years one day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1959 to December 1959 , that I last saw the deceased alive on December 24, 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John V. Conway, M.D.		ADDRESS (Street, city or town, state) 914 D Street DATE SIGNED 12-28-59	
PHYSICIAN'S NAME (Type) John V. Conway, M.D.		Balt. 19, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-28-1959	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Duda 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DATE DEC 29 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus



13529

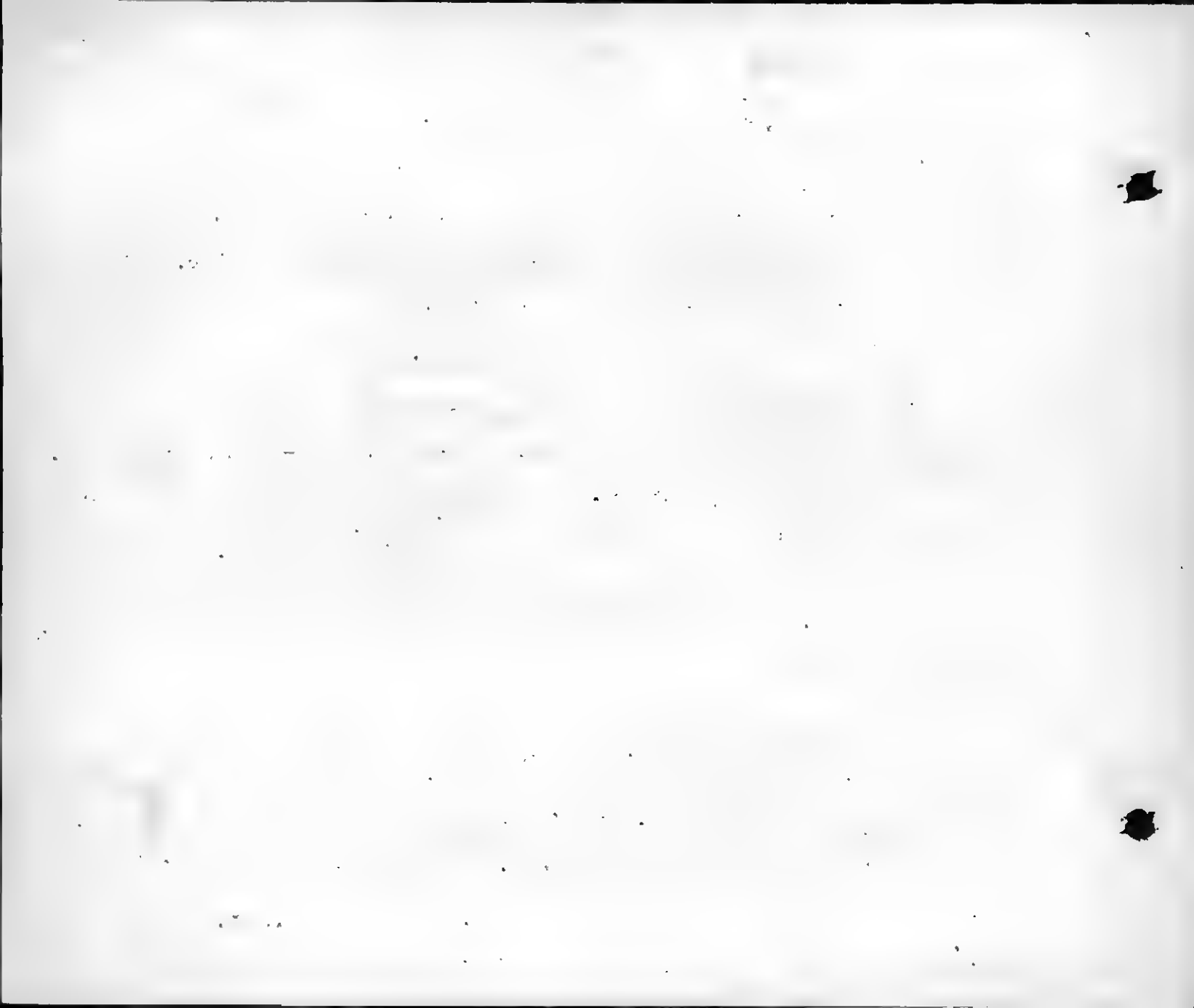
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 11 S. Woodington Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle WICKS Last		4. DATE OF DEATH Month Dec. Day 9 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Stewart		14. MOTHER'S MAIDEN NAME Emilie Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Advanced arteriosclerotic and hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 May, 1955 to 9 Dec, 1959 that I last saw the deceased alive on 9 Dec, 1959 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Emil H Henning Jr M.D.		ADDRESS (Street, city or town, state) 601 Winans Way DATE SIGNED 10 Dec 59	
PHYSICIAN'S NAME (Type) EMIL H HENNING JR MD		601 WINANS WAY (29)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto ADDRESS 17th Ma		24a. REC'D BY REGISTRAR DATE DEC 14 1959	24b. REGISTRAR'S SIGNATURE Wm. J. Dickner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

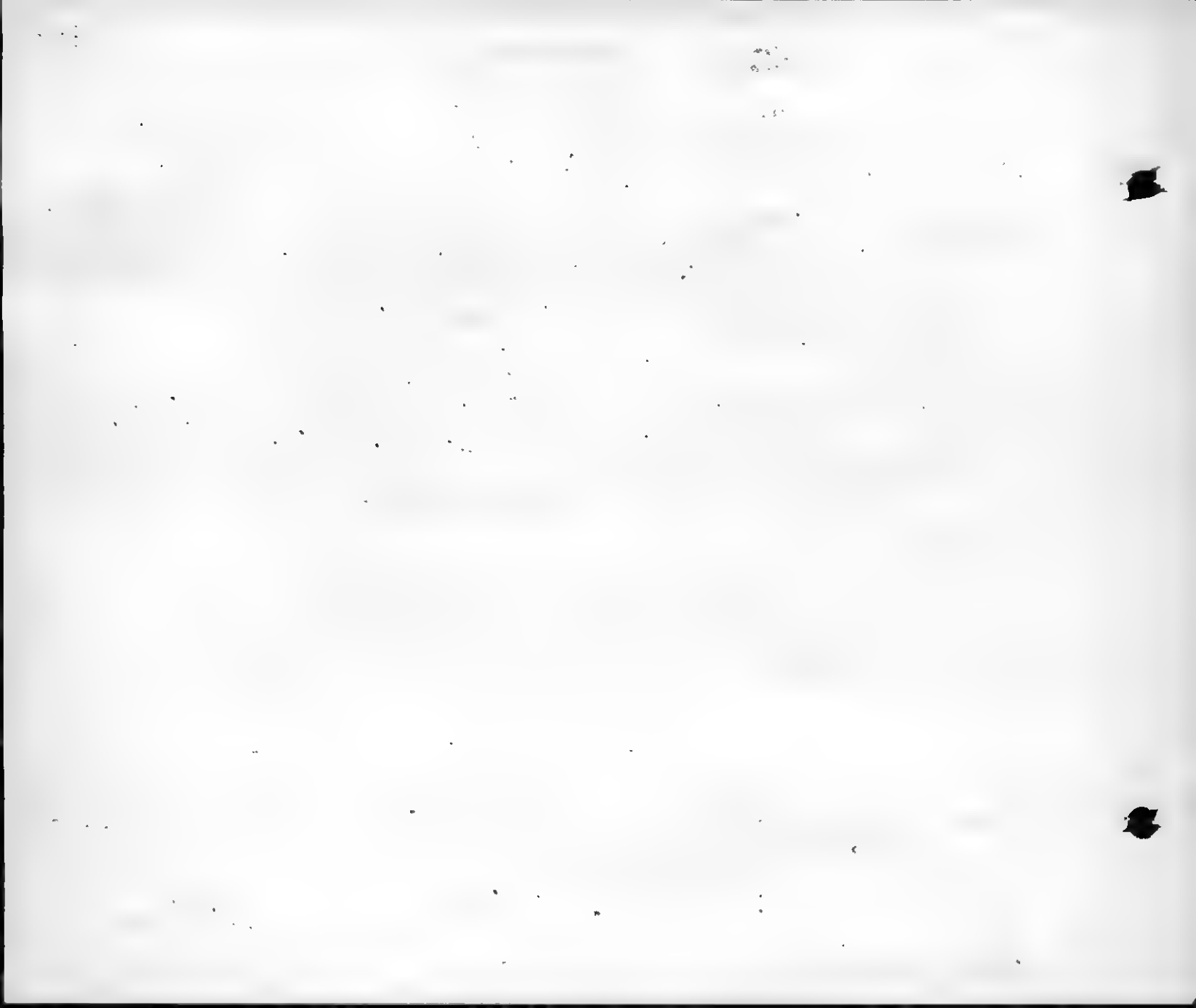
13530

CERTIFICATE OF DEATH

Reg. Dist. No.

13511

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eura Katherine Wilhelm</u>		4. DATE OF DEATH Month Day Year <u>December 20, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 25, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home Pizarro, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas L. Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Abigale Vest</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>L</u>	
17. INFORMANT <u>Melchor V. Wilhelm</u>		Address <u>Parkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1959</u> to <u>Dec. 20, 1959</u> that I last saw the deceased alive on <u>Dec. 19, 1959</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>12/21/59</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Foreston Baptist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Md. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u>		24a. REC'D BY REGISTRAR <u>DEC 24 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEE MACE WILLEY SR</u>				4. DATE OF DEATH <u>DEC 16 19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21 1901</u>	9. AGE (in years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>SHIPPING FOREMAN</u>			<u>STEEL</u>		<u>MARYLAND</u>		<u>U.S.A</u>
13. FATHER'S NAME <u>ISMAEL WILLEY</u>				14. MOTHER'S MAIDEN NAME <u>EMMA HURLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MAS LIDA WILLEY</u> Address <u>3214 NORTHVIEW RD</u>			
<u>NO</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO <u>mitral - aortic stenosis + insufficiency -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/14/59</u>		<u>OAK LAWN CEMETERY</u>		<u>GLAN GATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LARRY FURERMAN</u> ADDRESS <u>HOME 2112 DUNDALK AVE</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
				DATE <u>DEC 21 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13532

CERTIFICATE OF DEATH

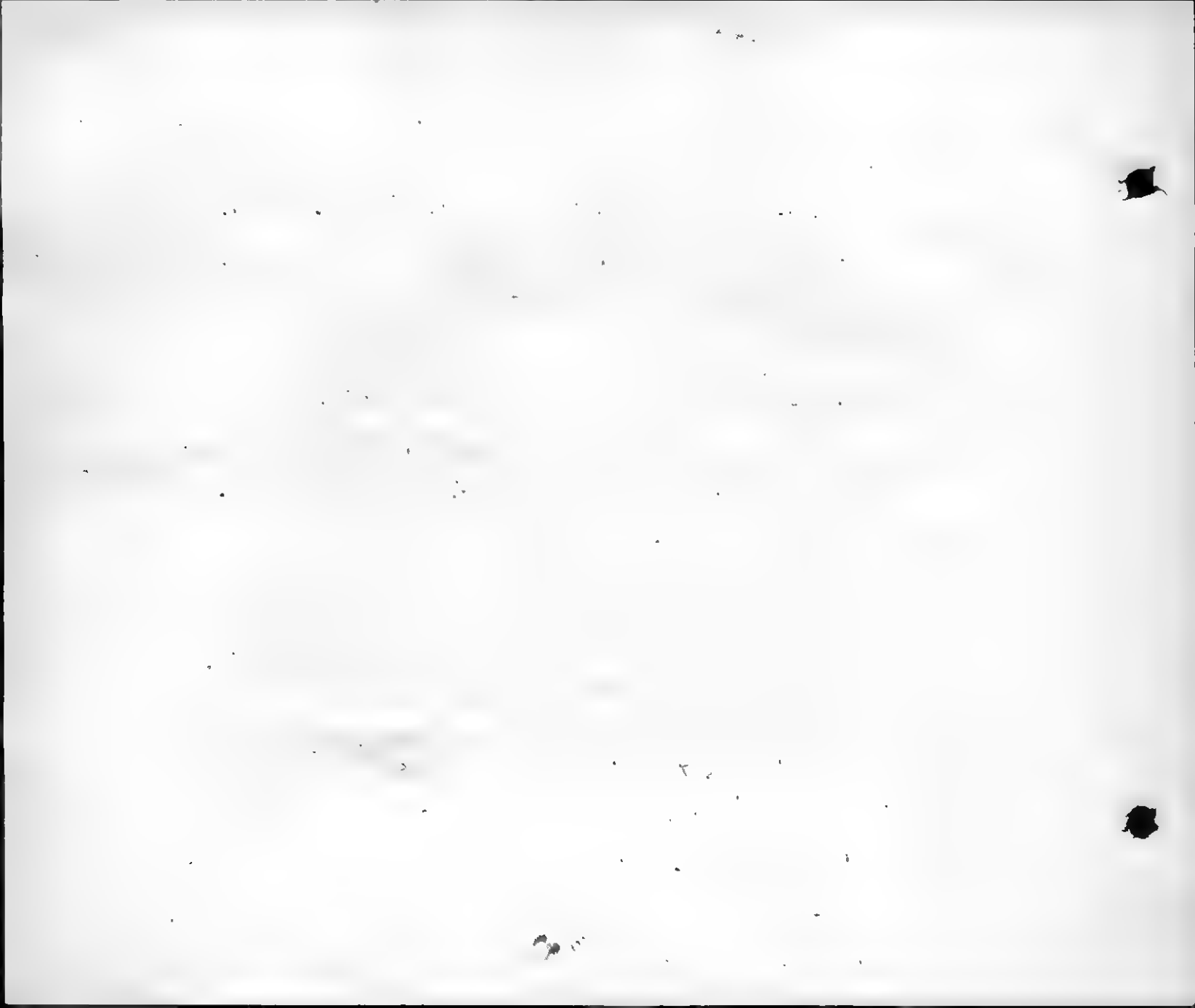
13513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Lansdowne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady nook Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>H.</u> Last <u>Wolf</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1890</u>
9. AGE (In years for birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Martha Griffith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>George W. Wolf</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular Disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Diabetes Mellitus</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26, 1958</u> to <u>December 13, 1959</u> that I last saw the deceased alive on <u>12 December 1959</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1118 ST PAUL ST. BALTIMORE, 2, MD</u>	
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>		DATE SIGNED <u>12-14-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '59</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13533

Items 8,9 Fill: 0253 12-24-59 et

CERTIFICATE OF DEATH

13514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE Maryland b. COUNTY 3V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (7)	
c. LENGTH OF STAY IN 1b 6 Hours		d. STREET ADDRESS 3906 N. Rogers Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MATTHEW Middle W. Last WOLPERT		4. DATE OF DEATH Month December Day 16 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1892 January 15, 1894
9. AGE (In years last birthday) 66 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale Jobber		10b. KIND OF BUSINESS OR INDUSTRY Tobacco Business	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Moishe Wolpert		14. MOTHER'S MAIDEN NAME Frieda Greenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Clin. Rec. VAH, Ft. Howard Division, Balto. 18, Md.		Address	

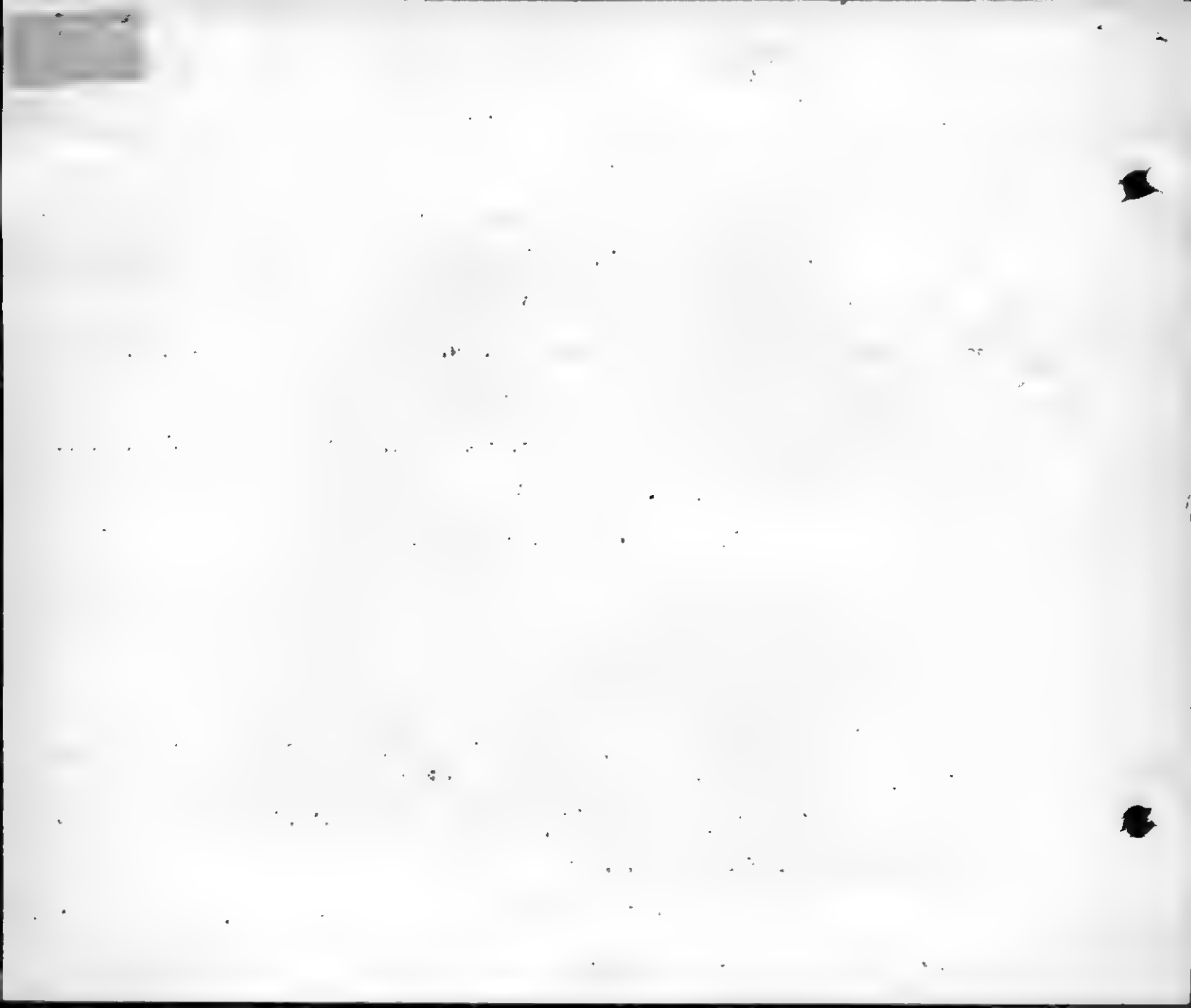
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 YRS.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA
20f. (City or town) Baltimore		(County) (State)

21. I certify that I attended the deceased from Dec. 16, 8:20AM '59 to Dec. 16, 2:20PM '59 and that death occurred at 2:20PM , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION
ACTUAL SIGNATURE Caridad E. Gonzalez		DATE SIGNED 12/16/59
PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-17-59	22c. NAME OF CEMETERY OR CREMATORY Rose Dale	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc., 2100 Rutaw Place, Balto. Md.		24a. REC'D BY REGISTRAR DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13515

13534

Item 16 - 11-11-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 1yrlmth13dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1909 Fleet Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen First Middle Last Verdia Ester Wolski		4. DATE OF DEATH Month December Day 10 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1913
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 10 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mr. Golden		14. MOTHER'S MAIDEN NAME Lena ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 234-26-4379	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging Conditions, if any, which gave rise to immediate cause (b) 714X (c) 714X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suicide			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found at 6:45 p.m. with hem of a garment tied to a door knob and around her neck.	
20c. TIME OF INJURY Hour 6:45 Minute PM Month, Day, Year 12-10 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	20f. (City or town) Catonsville 28, Maryland
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 12-11-59	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) 6515 Boston St. (Baltimore)
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber		24a. REC'D BY REGISTRAR DEC 15 '59	
ADDRESS 705 South Ann Street		24b. REGISTRAR'S SIGNATURE Adeline S. Thomas	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

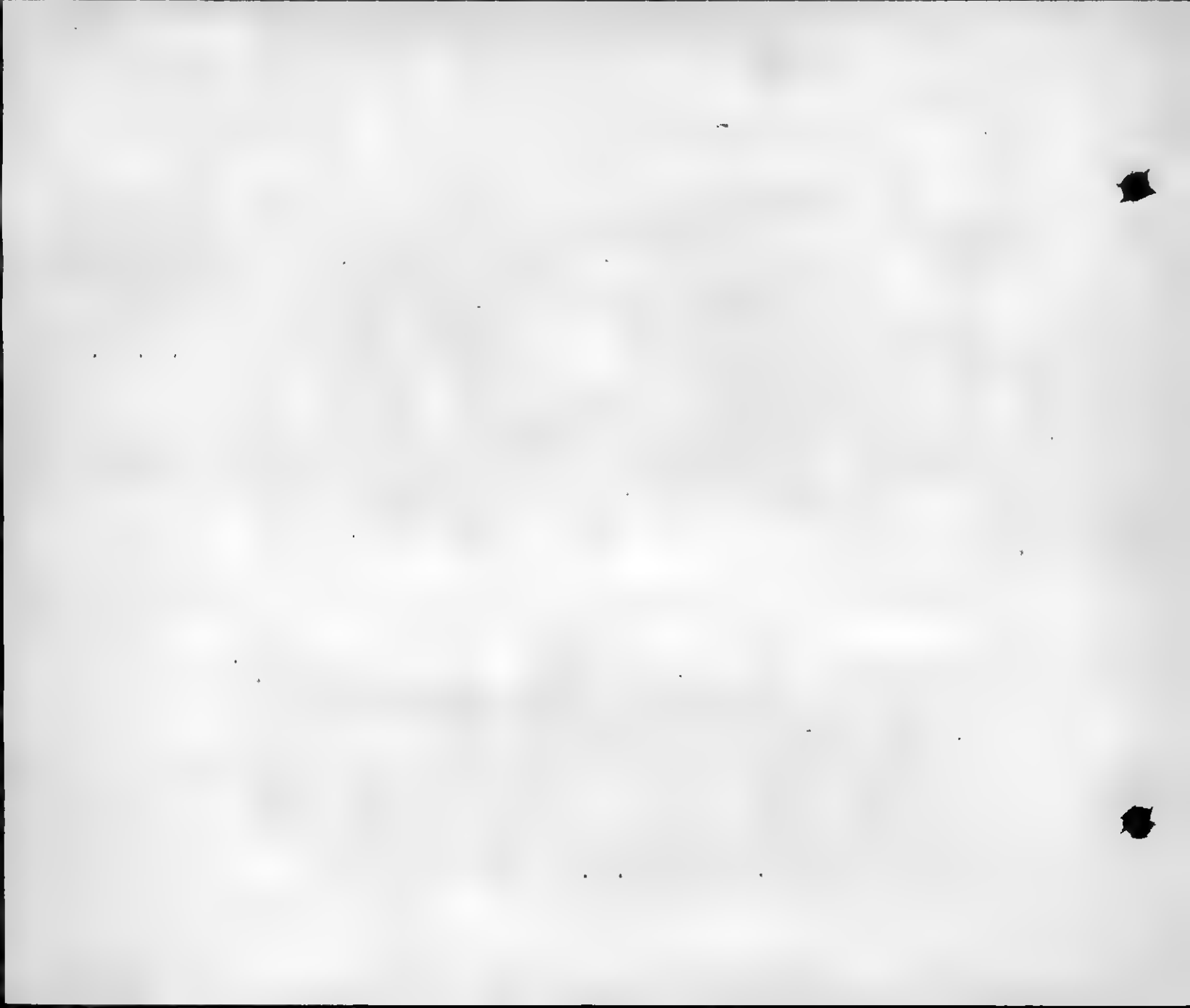


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 13516									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived If Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 6yr5mth2dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland			10x	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS Star Route - Box 404			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Wootten Last					4. DATE OF DEATH Dec 6 1959		Month 6 Day 19 Year 59		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1871?		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 147 DUE TO arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Fracture right femur (accident)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on 10-24-59 sustaining fractured right femur.						
20c. TIME OF INJURY Hour 7:00 P.M. Month, Day, Year 10-24-1959			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE George M. Kieffer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) George M. Kieffer, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.			22d. LOCATION (City, town, or county) (State) Calmar Manor Md		
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Will Handerson Laurel Md					24a. REC'D BY REGISTRAR DEC 10 1959		24b. REGISTRAR'S SIGNATURE Carling S. Hume		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

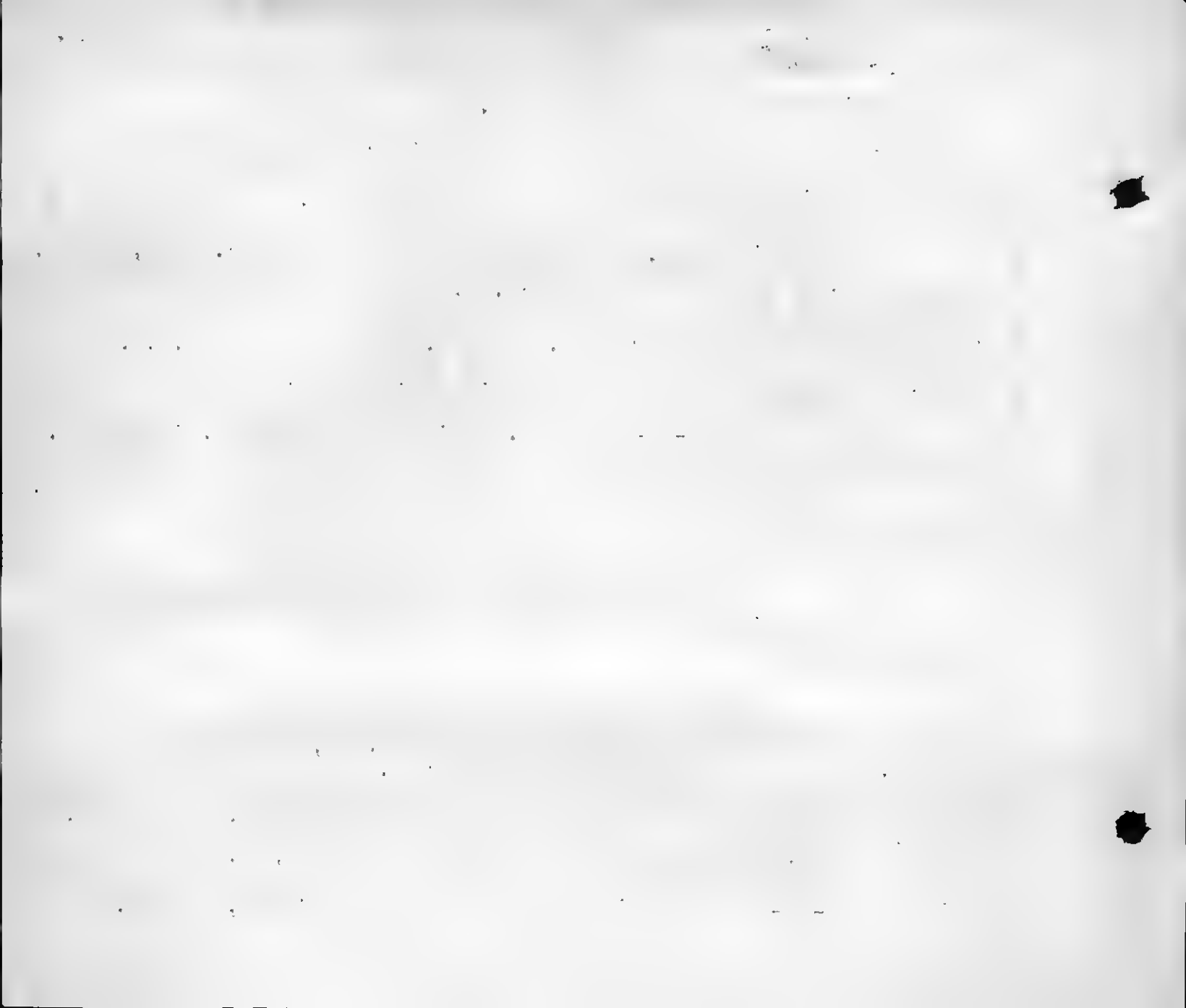
13536

CERTIFICATE OF DEATH

Reg. Dist. No.

13517

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 3912 Belle Ave..		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle A. Last Worthman		4. DATE OF DEATH Month Dec. Day 28. Year 1959.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Worthman		14. MOTHER'S MAIDEN NAME Wilhelmina Bolwie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-4958	
17. INFORMANT Mrs. Lillian Rodgers		Address 113 S. Wickham Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Urinary Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio-vascular Disease INTERVAL BETWEEN ONSET AND DEATH about 3 Mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month March Day 19 Year 1946 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1946 , to Dec. 28, 1959 , that I last saw the deceased alive on Dec. 28, 1959 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Mallow Hill Ave., Baltimore 29, Md. DATE SIGNED 12/29/59			
ACTUAL SIGNATURE Leo J. Gaver PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR DATE DEC 31 '59	
ADDRESS 3207 W. North Ave.		24b. REGISTRAR'S SIGNATURE Chas. S. Harris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13537

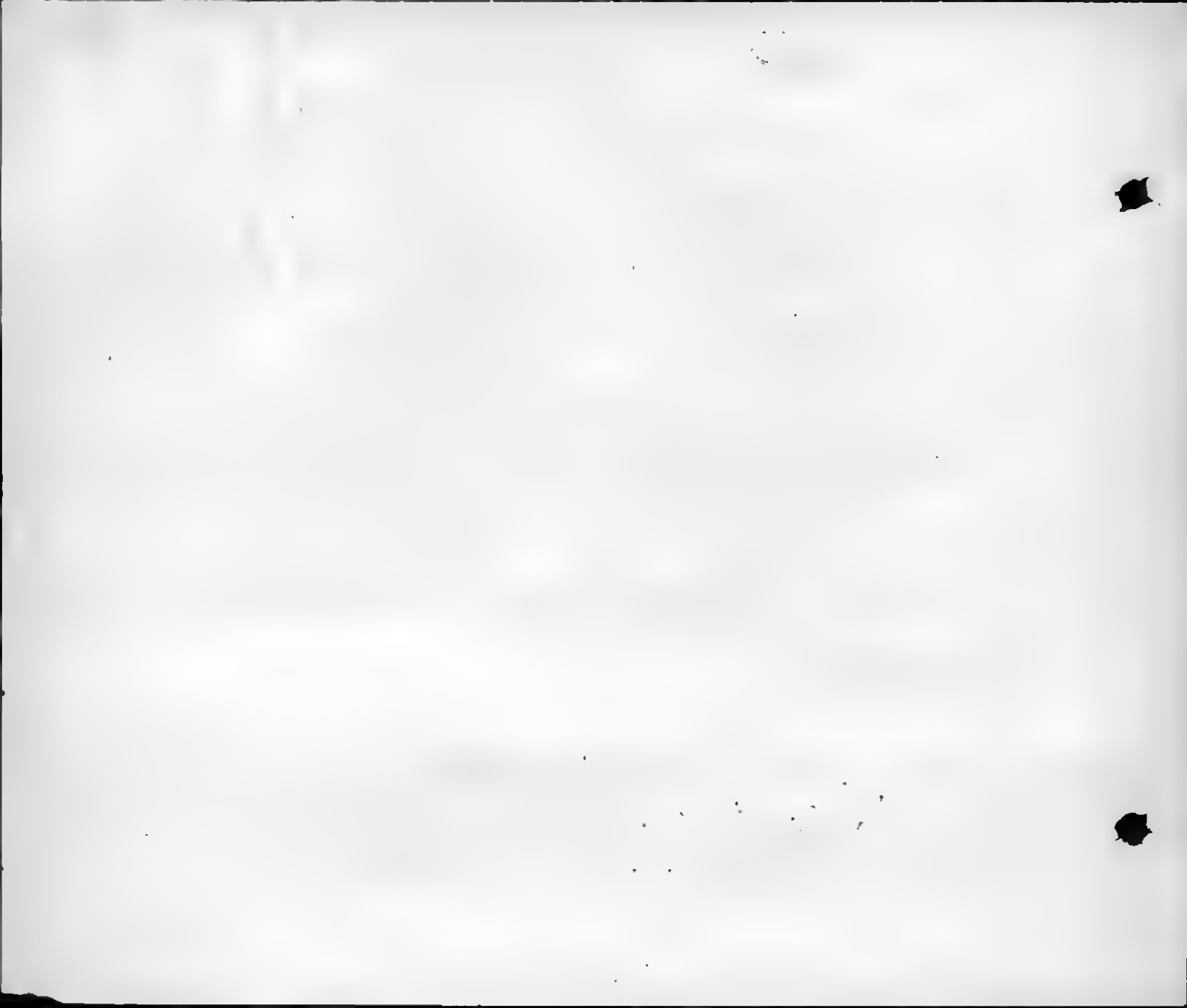
CERTIFICATE OF DEATH

13518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth2dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George W. Wratchford		4. DATE OF DEATH Month Day Year December 29 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1880
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	11. BIRTHPLACE (State or foreign country) W. Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. Has a card		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 26 , 19 59 , to Decm. 29 , 19 59 , that I last saw the deceased alive on Dec. 29 , 19 59 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED 12-29-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-60	
22c. NAME OF CEMETERY OR CREMATORY Catonsville 28, Maryland		22d. LOCATION (City, town, or county) (State) Catonsville 28, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 30 E. Fort Ave	
24a. REC'D BY REGISTRAR Jan 4 60		24b. REGISTRAR'S SIGNATURE Arthur J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



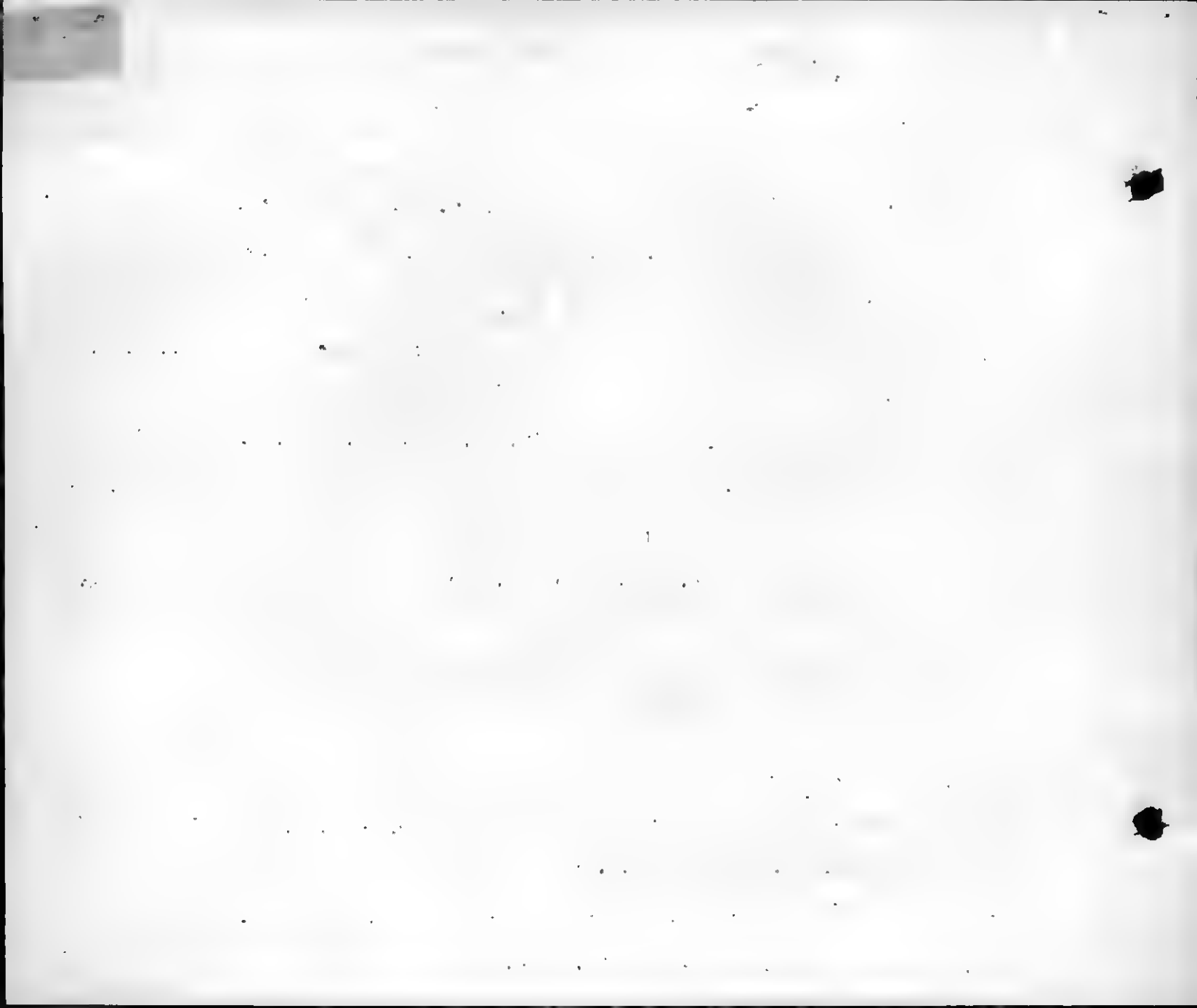
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13538 CERTIFICATE OF DEATH

13519

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 234 West Lafayette Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle GORSUCH Last YOUNG, JR.		4. DATE OF DEATH Month December Day 16 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1911
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 4 Days 16 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas G. Young		14. MOTHER'S MAIDEN NAME Isabel Evans Mundy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. 213-03-7474	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC INSUFFICIENCY 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) LAENNEC'S CIRRHOSIS OF LIVER (c) CHRONIC PEPTIC DUODENAL ULCER INTERVAL BETWEEN ONSET AND DEATH 4 Days SEVERAL YRS. UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 12, 1959 to December 16, 1959 and that death occurred at 6:55AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION DATE SIGNED 12/16/59 ACTUAL SIGNATURE Caridad E. Gonzalez PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-59	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.		24a. REC'D BY REGISTRAR DEC 21 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13520

13539

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1752 1752 Aberdeen Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George N. Zellinger Jr.				4. DATE OF DEATH Month Day Year December 23 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Makers Helper				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George N. Zellinger Sr.				14. MOTHER'S MAIDEN NAME Kate Lennbaum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI				16. SOCIAL SECURITY NO. 213-03-2703A			
17. INFORMANT Sophia Zellinger				Address 1752 Aberdeen Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arterio sclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/15, 1957 to 12/23, 1959 , that I last saw the deceased alive on 12/25, 1959 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon Grau				ADDRESS (Street, city or town, state) DATE SIGNED 1523 York River Bldg 12/26/59			
PHYSICIAN'S NAME (Type) Edward Gordon Grau							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran				ADDRESS 3000 E. Baltimore St. Balto.		24a. REC'D BY REGISTRAR DEC 29 '59	
				24b. REGISTRAR'S SIGNATURE Gordon S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13521

13540

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lavinia</u> Last <u>Zimmer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>11</u> Hours <u>11</u> Min.	11. IF UNDER 24 HRS. Months <u>22</u> Days <u>11</u> Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltio. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henery Allers</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Mullineaux</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. George W. Zimmer, 217 Church Lane, Pikesville 8, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>22 mons.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 24th</u> , 19 <u>58</u> , to <u>Dec. 11th</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Dec. 11th</u> , 19 <u>59</u> , and that death occurred at <u>5:11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		DATE SIGNED <u>12/13/59</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd., Pikesville - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1851

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

[Faint, illegible handwritten text covering the majority of the page]